IDAHO DEPARTMENT OF
HEALTH & WELFARE

JAMES E. RISCH – Governor
RICHARD M. ARMSTRONG – Director

DEBRA RANSOM, R.N.,R.H.I.T., Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, ID 83720-0036
PHONE 208-334-6626
FAX 208-364-1888

CERTIFIED MAIL: 7000 1670 0011 3314 8880

July 3, 2006

Steve Holloway, Administrator
Lacrosse Health & Rehabilitation Center
210 West Lacrosse Avenue
Coeur D'Alene, ID 83814

Provider #: 135042

Dear Mr. Holloway:

On **June 19, 2006**, a Recertification survey was conducted at Lacrosse Health & Rehabilitation Center by the Bureau of Facility Standards/Department of Health & Welfare to determine if your facility was in compliance with State Licensure and Federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. This survey found that your facility was not in substantial compliance with Medicare and Medicaid program participation requirements. **This survey found the most serious deficiencies to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy, as evidenced by the attached CMS-2567 whereby significant corrections are required.**

Enclosed is a Statement of Deficiencies/Plan of Correction, CMS Form 2567L, listing Medicare/Medicaid deficiencies, and a similar form listing licensure health deficiencies. In the spaces provided on the right side of each sheet, answer each deficiency and state the date when each will be completed. **Please provide ONLY ONE completion date for each Federal/State Tag in column X5 (Complete Date), to signify when you allege that each tag will be back in compliance. NOTE: The alleged compliance date must be after the "Date Survey Completed" (located in field X3) and on or before the "Date Certain" (listed on page 2). After each deficiency has been answered and dated, the administrator should sign both the CMS Form 2567L and State Statement of Deficiencies, in the spaces provided, and return the originals to this office.**

Your Plan of Correction (PoC) for the deficiencies must be submitted by **July 17, 2006**. Failure to submit an acceptable PoC by **July 17, 2006**, may result in the imposition of civil monetary penalties by **August 7, 2006**.

Your PoC must contain the following:

- What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;
- How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken;
- What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur;
- How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and,
- Include dates when corrective action will be completed.

All references to federal regulatory requirements contained in this letter are found in *Title 42, Code of Federal Regulations*.

Remedies will be recommended for imposition by the Centers for Medicare and Medicaid Services (CMS), if your facility has failed to achieve substantial compliance by **July 24, 2006 (Date Certain)**. Informal dispute resolution of the cited deficiencies will not delay the imposition of the enforcement actions recommended (or revised, as appropriate) on **July 24, 2006**. A change in the seriousness of the deficiencies on **July 24, 2006**, may result in a change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by **July 24, 2006** includes the following:

Denial of payment for new admissions effective **September 19, 2006**. [42 CFR §488.417(a)]

If you do not achieve substantial compliance within three (3) months after the last day of the survey identifying noncompliance, the CMS Regional Office and/or State Medicaid Agency must deny payments for new admissions.

We must recommend to the CMS Regional Office and/or State Medicaid Agency that your provider agreement be terminated on **December 19, 2006**, if substantial compliance is not achieved by that time.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

If you believe these deficiencies have been corrected, you may contact Loretta Todd, R.N. or Lorene Kayser, L.S.W., Q.M.R.P., Supervisors, Long Term Care, Bureau of Facility Standards, 3232 Elder Street, PO Box 83720, Boise, ID 83720-0036, Phone #: (208) 334-6626, Fax #: (208) 364-1888, with your written credible allegation of compliance. If you choose and so indicate, the PoC may constitute your allegation of compliance. We may accept the written allegation of compliance and presume compliance until substantiated by a revisit or other means. In such a case, neither the CMS Regional Office nor the State Medicaid Agency will impose the previously recommended remedy, if appropriate.

If, upon the subsequent revisit, your facility has not achieved substantial compliance, we will recommend that the remedies previously mentioned in this letter be imposed by the CMS Regional Office or the State Medicaid Agency beginning on **June 19, 2006** and continue until substantial compliance is achieved. Additionally, the CMS Regional Office or State Medicaid Agency may impose a revised remedy(ies), based on changes in the seriousness of the non-compliance at the time of the revisit, if appropriate.

In accordance with 42 CFR §488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. To be given such an opportunity, you are required to send your written request and all required information as directed in Informational Letter #2001-10. Informational Letter #2001-10 can also be found on the Internet at:

http://www.healthandwelfare.idaho.gov/_Rainbow/Documents/medical/2001_10.pdf
http://www.healthandwelfare.idaho.gov/_Rainbow/Documents/medical/2001_10_attach1.pdf

This request must be received by **July 17, 2006**. If your request for informal dispute resolution is received after **July 17, 2006**, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

Thank you for the courtesies extended to us during the survey. If you have any questions, please contact us at (208) 334-6626.

Sincerely,

Lorene Kayser

LORENE KAYSER, L.S.W., Q.M.R.P.
Supervisor
Long Term Care

LKK/dmj

Enclosures

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135042	A. BUILDING _____ B. WING _____	06/19/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LACROSSE HEALTH & REHAB	210 W LACROSSE AVE COEUR D'ALENE, ID 83814

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F 000	INITIAL COMMENTS The following deficiencies were cited at the annual recertification survey at your facility. Surveyors conducting the annual survey were: Nicole Martin, BSN RN, Team Coordinator Kari Head, MS RDLD Diane Miller, LCSW Survey Definitions: MDS = Minimum Data Set assessment RAI = Resident Assessment Instrument RAP = Resident Assessment Protocol DON = Director of Nursing LN = Licensed Nurse RN = Registered Nurse CNA = Certified Nurse Aide ADL = Activities of Daily Living MAR = Medication Administration Record	F 000	Submission of this plan of correction does not constitute an admission by the provider of any fact or conclusion set forth in this statement of deficiency. This plan of correction is being submitted because it is required by law. RECEIVED JUL 17 2006 FACILITY STANDARDS	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Thomas Holloway — TITLE: Administrator — (X6) DATE: 7/14/06

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 157 SS=D	483.10(b)(11) NOTIFICATION OF CHANGES A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview it was determined the facility did not ensure a resident's physician was notified in a timely manner when a resident experienced an acute change in	F 157	It is the policy of Lacrosse Health and Rehab to inform resident's physicians of changes in resident status. Please note that the resident's physician was updated twice during the residents brief spell of nausea/vomiting/diarrhea and orders were received to treat the symptoms as they arose. All symptoms resolved without complication. To enhance currently compliant operations and under the direction of the DON, on 7/13/06 all licensed nurses will receive in-service training regarding state/federal and facility policies concerning physician notification. The training will emphasize when physician notification is required as well as frequency of notification. Because all residents are potentially affected by the cited deficiency, each RCM will audit the facilities "24 Hour Report" to ensure changes in resident condition are reported to the physician per policy. Under the direction of the DON, this quality assurance program will be implemented on 7/14/06. Any deficiencies will be corrected on the spot, and the findings of the quality assurance checks will be submitted at the quality assurance committee meetings for further review or corrective action.	7/24/06

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F 157	Continued From page 2 condition. This was true for 1 of 21 sampled residents (#7). Findings include: Resident #7 was admitted to the facility on 4/14/06 with the diagnoses of congestive heart failure, asthma, chronic obstructive pulmonary disease, dementia and status post femur fracture. The resident's "Problem Oriented - Progress Notes," (nursing notes), documented the following: *6/6/06 at 10:30 am, "...C/O [complaints of] nausea this am [morning]. States she'd like some alka-seltzer. Fax to MD [and] given 7-Up. nausea did subside [with] carbonated beverage / will observe." At 9:30 pm another entry documented, "...C/O upset stomach this evening before dinner..." *6/7/06 at 10:30 am, "...No c/o gi [gastrointestinal] upset this am but does have large loose BM [bowel movement]..." *6/9/06 at 4:30 am, "...[up] to toilet x [times] [one] had started having BM on mat pulling brief [down] back to bed sleeping [at] this time." At 12:30 pm another entry documented "...Has diarrhea..." *6/10/06 at 11:00 am, "Afebrile. Resident had 1 x emesis the am [and] diarrhea x 2." At 8:30 pm another entry documented, "Resident has c/o [complained of] not feeling well all shift. She did not eat any dinner this eve [evening] [and] drank very little fluids, had a slight T [temperature] 99.1 Will cont[inue] to monitor." *6/11/06 at 10:00 pm, "Resident has not eaten	F 157		

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F 157	Continued From page 3 any food this shift did drink some fluids [and] a novasource, has been [up and down] in bed serveral times this eve..." *6/12/06 at 10:45 pm, "diarrhea cont refused dinner - c/o upset stomach OOB [out of bed] most of shift. [no] new issues [at] this time." *6/13/06 at 2:50 am, "Resident has had diarrhea this shift. [No] c/o GI upset [no] vomiting noted...". Resident #7's bowel records were reviewed and documented the resident had diarrhea on 6/9, 6/10, 6/11 and 6/12/06. On 6/15/06 at 8:45 am, the DON was asked to provide documentation of when the resident's physician was notified related to the resident's acute GI distress. He returned with the following faxes: "6/6/06, Res c/o nausea (requested alka seltzer) she has no order for Mylanta or anything else for nausea or GI upset. This happened [before] breakfast Fri[day], Mon[day] and today. No emesis, but ref[used] to eat. Did eat other meals. We have had some other Res [with] N/V [nausea and vomiting]." "6/14/06, Res cont to have poor appetite [with] episodes of nausea - Mylanta is helpful, Has had some episodes of diarrhea. Miralax being held since Monday. Diarrhea is less but still has occ [occasional] episodes diarrhea." Resident #7 complained of nausea and the resident's physician was notified on 6/6/06. The resident's symptoms increased to include	F 157		

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F 157	Continued From page 4 vomiting, diarrhea, loss of appetite and a low grade fever. The resident's physician was not notified when the symptoms increased. In fact, the resident's physician was not notified of the increased symptoms until 6/14/06 after the diarrhea had subsided. When the facility notified the physician on 6/14/06, they did not indicate that the resident had had diarrhea for four days, had episodes of vomiting, or that the resident was refusing to eat and consumed very little fluids for two days. The facility failed to ensure resident #7's physician was fully informed of her acute medical condition in a timely manner.	F 157		

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F 164 SS=E	483.10(e), 483.75(l)(4) PRIVACY AND CONFIDENTIALITY The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility. The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law. The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident. This REQUIREMENT is not met as evidenced by: Based on observation and medical record review, it was determined the facility failed to provide personal privacy and confidentiality of the residents personal and clinical records. Staff and residents not involved in the care of the resident should not be present without the resident's	F 164	It is the policy of Lacrosse Health and Rehab to provide for resident privacy and confidentiality during physician examinations. To enhance currently compliant operations and under the direction of the DON, on 7/13/06 the licensed staff will receive in-service training regarding federal/state and facility requirements concerning providing for resident privacy during physician visits. Because all residents that have physician visits within the facility are potentially affected by the cited deficiency, during the week of 7/10/06 a letter will be mailed to all physicians that see their patients at the facility. This letter will address the issues of confidentiality and privacy that will be expected during their visits to the facility. The licensed staff will monitor and ensure physician compliance. Effective 7/13/06, a quality assurance program will be implemented under the supervision of the DON to monitor compliance of the physicians with state/federal and facility requirements of providing for resident privacy and confidentiality during examinations. Any concerns in this area will be corrected on the spot. Any problem physicians will be discussed during the quality assurance committee meetings. The medical director will be asked to contact any physicians that have issues with providing for resident privacy.	7/24/06

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F 164	Continued From page 6 consent while the resident is being examined or treated. This was true for 4 random residents (#22, 23, 26 and 31). Findings include: 1. On 6/14/06 at 12:25 pm, during the lunch meal on the Special Care Unit in the larger dining room, a physician and the resident care manager for the Special Care Unit were observed approaching random resident #22 while he was sitting at the table with his lunch in front of him. One other resident was seated at the table. The resident was observed with his eyes closed and sitting still. The surveyor observed the physician shaking the resident's left shoulder in attempts to wake him up. Without asking the resident if it would be okay to examine him, the physician proceeded to place his stethoscope on the front of the resident's body and then on his back. The physician asked the resident several questions regarding his present functioning level. The physician and resident care manager then walked away from the resident. There were 16 other residents present in the dining room eating lunch during this time. 2. On 6/14/06 at 12:30 pm, during the lunch meal on the Special Care Unit in the larger dining room, a physician and the resident care manager for the Special Care Unit were observed approaching random resident #23. The resident was sitting at the table with her lunch in front of her with three other residents seated at the table and 1 staff person. The resident was observed with her eyes closed and sitting still. The surveyor observed the physician shaking the resident's left shoulder in attempts to wake her up. Even though he was unable to wake her, he proceeded to place his stethoscope on the front of the	F 164		

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F 164	Continued From page 7 resident's body and then on her back. The physician and resident care manager then walked away from the resident. There were 16 other residents present in the dining room eating lunch during this time. 3. On 6/14/06 at 12:35 pm, during the lunch meal on the Special Care Unit in the smaller dining room, a physician and the resident care manager for the Special Care Unit were observed approaching random resident #31 while she was sitting at the table with her lunch in front of her. Three other residents were seated at the table. She was actively eating her lunch. The physician asked the resident a few medically related questions. The resident did not stop eating so the physician did state that he would not interrupt her meal. The physician and resident care manager then walked away from the resident. There were 6 other residents present in the dining room eating lunch during this time. 4. On 6/15/06 at approximately 3:30 pm, a physician approached the nurses station on the Special Care Unit requesting to see resident #26. The resident care manager reported that resident #26 had just left the unit to go participate in bingo. The resident care manager requested that a CNA locate resident #26 and bring her back to the Special Care Unit so he could meet with the resident. Approximately 5 minutes later, the CNA returned to the Special Care Unit with resident #26. In the hallway about 15 feet inside the locked door of the Special Care Unit, outside of two resident rooms, and in view of 2 anonymous male residents and 2 anonymous female residents, the physician performed a medical examination of resident #26. The resident care manager and a	F 164		

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F 164	Continued From page 8 CNA on the Special Care Unit were present also. The examination was completed in about 5 minutes. On 6/16/06 at approximately 9:30 am, a staff interview was conducted with the resident care manager of the Special Care Unit regarding physicians not respecting residents rights to privacy and confidentiality. The resident care manager stated, "We are happy that the physicians come to the facility to see the residents. If we start putting rules on the physicians of where they can and cannot see the residents, they will stop coming to the facility and then we will be in trouble for residents not being seen medically." The resident care manager then asked the surveyor, "What am I suppose to do?" The facility did not ensure that the residents privacy and confidentiality regarding personal and clinical records were protected.	F 164		

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F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) STAFF TREATMENT OF RESIDENTS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced	F 225	It is the policy of Lacrosse Health and Rehab to thoroughly investigate unwitnessed falls to rule out neglect. It is also the policy of Lacrosse Health and Rehab to ensure a thorough screening process is conducted for potential employees. To enhance currently compliant operations and under the direction of the DON, on 7/13/06 all licensed staff will be in-serviced concerning the definition of a "fall." The training will emphasize the importance of investigating unwitnessed falls. On 7/11/06 all nursing assistants will be in-serviced concerning the definition of a fall and reporting such events to the licensed staff as soon as possible. The SDC will be in-serviced on 7/13/06 concerning the state/federal and facility requirements regarding the screening process for all new employees. Please note that a copy of the nurses license was obtained and placed in her personnel file during the survey. The criminal background check has been completed. An investigation concerning the resident who exited her hi-lo bed showed no evidence of neglect. Because all fall risk residents on hi-lo beds are potentially affected by the cited deficiency, on 7/14/06 the DON audited medical records of all residents on hi-lo beds. No other residents have	7/24/06

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F 225	Continued From page 10 by: Based on record review, accident report review, review of facility employee files, and staff interview, it was determined the facility failed to thoroughly investigate unwitnessed falls to rule out neglect. This affected 1 of 18 sample residents (#7) evaluated for falls. The facility also failed to ensure a thorough screening process was completed for potential employees. This affected 2 of 5 recently hired employees (employees A and D). Findings include: 1. IDAPA 16.05.05 states, "The Idaho Legislature under Section 56-1004A, Idaho Code, has granted the Department of Health and Welfare the power and authority to participate in a federal pilot project to conduct criminal history and background checks for individuals in long term care settings that have direct patient access. The provisions of this rule will be effective from October 1, 2005 through September 30, 2007..." On 6/15/06 at 1:30 pm, the personnel records for five employees hired within the previous four months were reviewed. Review of employee D's employee file revealed the employee was previously employed by the facility in September 2005. The employee then terminated her employment and was rehired on 5/3/06. Further review of the record revealed the facility did not complete a criminal history check through the Idaho Department of Health and Welfare Criminal History Unit when the employee was rehired on 5/3/06. 2. Review of employee A's employee file revealed the employee was hired on 3/6/06. Further review of the record indicated the facility did not ensure	F 225	documentation that would indicate an unwitnessed fall was not investigated. All personnel files have been audited by the SDC to ensure all state/federal and facility requirements concerning licensure verification and background checks have been met. No other files were missing required documentation. Effective 7/14/06 a quality assurance program was implemented under the supervision of the DON to monitor for investigations of unwitnessed falls. The DON or designee will complete random audits of medical records to ensure an Accident and Incident Investigation is initiated for all unwitnessed falls. The administrator or his designee will complete random personnel file audits to ensure all required documentation is present. Any deficiencies will be corrected on the spot, and the findings of the quality- assurance checks will be documented and submitted at the quality assurance committee meeting for further review or corrective action.	

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	135042	A. BUILDING _____ B. WING _____	06/19/2006

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F 225	Continued From page 11 that a copy of the employee's professional licensure was on file to verify her license was in good standing. On 6/15/06 at 1:30 pm, the Human Resource Manager was interviewed. The manager stated that when employee D was re-hired on 5/3/06, the employee had not been terminated from the facility for more than 6 months, therefore, they thought that they did not have to complete another criminal history check even though the first criminal history check was not completed through the Idaho Department of Health and Welfare Criminal History Unit. The manager also stated they had requested a copy of employee A's licensure when the employee was hired, however, they had not received it. She stated they did verify by telephone that her licensure was current, but had not yet obtained a copy for her file. 3. Resident #7 was admitted to the facility on 4/14/06 with the diagnoses of congestive heart failure, asthma, chronic obstructive pulmonary disease, dementia and status post femur fracture. The resident's admission MDS, dated 4/24/06, documented the resident required extensive assistance of one staff for bed mobility, transfers and toileting and was moderately cognitively impaired. The resident's "Problem Oriented - Progress Notes" documented on 6/9/06 at 4:30 am, "...Unsafe [with] self transfers trying to stand up [and] gets herself out of bed onto mat. [Up] to toilet x [times] [one] had started having BM [bowel movement] on mat pulling brief [down]. Back to bed sleeping [at] this time." There was no	F 225		

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F 225	Continued From page 12 additional documentation in these notes indicating the last time the resident was toileted or if the resident's call light was within reach. The facility's "Accident/Incident Reports" were reviewed and an investigation was not found for the incident where resident #7 was found on the mat by her bed. On 6/15/06 at 8:45 am, the DON was interviewed and asked to locate the investigation into the incident on 6/9/06 where the resident was found out of bed on the mat. The DON indicated he would look into it. At 9:45 am, the DON returned and acknowledged there was no investigation into that incident because it was considered a "roll out of a low bed onto a mat," and was therefore not considered a fall and would not be investigated. Resident #7's "Care Delivery Guide," dated 5/4/06, documented the resident was a "High Fall Risk" and had "[no] safety skills." This form also documented under "safety," "Cue to WB [weight bearing] status. Does not remember [decreased] WB status - tries to stand." The resident's "Fall/Injury Assessment: Prevention and Management Plan of Care" dated 4/14/06, did not indicate or document the resident was frequently found on the mat by the bed or that the resident had multiple rolls out of bed to the mat when the bed was in the low position. Resident #7 was identified by the facility as a high risk for falls. Care planned interventions included a hi-low bed with a mat by the bed. There was no documentation on the resident's fall risk assessment or care plan that indicated the resident routinely rolled out of her bed in the low	F 225		

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F 225	Continued From page 13 position to the mat on the floor. The nurse's notes documented the resident was found on the mat on 6/9/06 while she was trying to go to the bathroom. There was no investigation into this event to determine the circumstances surrounding this incident in order to determine if a repeat occurrence could be prevented or to rule out the possibility of abuse. This is a repeat deficiency from the annual recertification survey of 5/13/05.	F 225 F241	It is the policy of Lacrosse Health and Rehab to promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect. To enhance currently compliant operations and under the direction of the DON, on 7/11/06 the nursing assistants and on 7/13/06 the licensed nurses will receive in-service training regarding state/federal and facility requirements regarding maintaining resident dignity. The training will emphasize staff knocking on resident room doors, providing hygiene to present a dignified appearance and dressing residents on night shift. Each RCM will review their residents and update the care plans as necessary for those residents that awaken early and request to be assisted in getting out of bed. Because all residents are potentially affected by the cited deficiency, on 7/14/06 each RCM will asses their female residents to ensure they have received adequate facial hair care in order to present a dignified appearance. Random audits will be conducted by the DON or designated representative to ensure staff are knocking on resident room doors and that night shift is not awakening residents or dressing them unless they request this service. Any deficiencies will be corrected on the spot.	7/24/06
F 241 SS=E	483.15(a) DIGNITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, it was determined the facility did not ensure 4 of 18 sampled residents (#'s 5, 14, 16 and 18), 1 random residents (# 27) and one random unidentified resident in room #215 were provided care which enhanced their dignity. a. Residents were awakened and dressed at an early hour for staff convenience. b. Residents were not provided with personal hygiene care to present a dignified appearance. c. Staff were observed entering residents rooms without knocking and asking permission to enter.	F 241		

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F 241	Continued From page 14 The findings include: 1. a. Resident #5 was observed on 6/13/06 at 7:00 am, 7:30 am and 7:45 am, sleeping in her bed in her room. At 8:00 am, a CNA entered resident #5's room to awaken her for breakfast. The resident was fully dressed except for shoes and was sleeping in her bed. The resident refused to get up for breakfast. Review of the Meal Consumption Records revealed the following: March 2006 slept through 14 breakfasts; April slept through 10 breakfasts and May slept through 8 breakfasts. Nursing notes on 4/14/06, documented, "...sleeps through breakfast most mornings..." The nursing note on 4/14/06, documented, "...sleeps thru breakfast most mornings..." The CNA was asked why the resident was already dressed. The CNA reported, "the night shift gets a few residents dressed each morning around 5:30 am, and puts them back to bed in order to help out the day shift." b. On 6/14/06 at 5:30 am, resident #18 was observed in her room asleep in her bed. At approximately 5:50 am, resident #18 turned her call light on for assistance. The surveyor accompanied the CNA into the resident's room. The resident asked the CNA some questions and then went back to sleep. The surveyor observed that the resident was fully dressed except for shoes at this time. The resident got up for the day at 7:20 am, on her own.	F 241	The findings of this quality-assurance program will be documented and submitted at the quality-assurance committee meetings for further review or corrective action.	

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F 241	Continued From page 15 The CNA was asked why the resident was already dressed. The CNA reported, "The night shift, each morning around 5:00 am or so, gets 2-3 residents dressed and puts them back to bed as a courtesy to the day shift." She stated that she didn't feel that it was right to get them up and dressed and put back to bed. She said she was just doing what she was told to do. The surveyor asked what other residents they had gotten up and dressed and put back to bed on 6/14/06. The CNA reported that the only other resident on this day was resident #16. c. Resident #16 had been observed asleep in her bed at 5:30am, 6:30 am, and 7:00 am. The surveyor accompanied the CNA into random resident #16's room at 7:15 am to answer her call light. Resident #16 was fully dressed except for her shoes and was lying in her bed. d. On 6/16/06 at 6:45 am, the surveyor accompanied the CNA to answer a call light for random resident #27. The resident asked to be gotten up for the day. The surveyor observed that the resident had her night gown on and a pair of dress slacks. The CNA proceeded to change random resident #27's brief, assist her in removing her night gown and putting on a blouse that went with the slacks that she had on. The CNA was asked why the resident was wearing dress slacks and her night gown. The CNA stated that she wasn't sure. On 6/16/06 at approximately 7:30 am, the resident care manager was interviewed regarding why random resident #27 would have dress slacks on with her night gown. At first the resident	F 241		

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F 241	Continued From page 16 care manager stated that possibly the resident had gotten up earlier in the morning and went back to bed. When the surveyor pointed out that the resident had on her nightgown and that the blouse she put on was still neatly folded and had not been worn, she had no answer to that. The surveyor asked her if it was a practice of the Special Care Unit to get residents dressed and put them back to sleep. She stated, "the CNA's do not know if a resident is going to get up or not. They might get a resident dressed who they think is going to stay up." When the resident care manager was made aware of the interview that the surveyor had had on 6/14/06 with a CNA who stated that they regularly, as a courtesy to the day shift, get 2-3 residents dressed and put back to bed she didn't deny the practice. e. Resident #14 was admitted to the facility on 6/3/02 with the diagnoses of dementia, cerebral vascular accident, chronic pain syndrome, osteoporosis and macular degeneration. The resident's most recent quarterly MDS, dated 5/18/06, documented the resident was severely cognitively impaired and required total assistance of one to two staff for bed mobility, transfers, dressing, toileting, and personal hygiene. This MDS also documented the resident was totally incontinent of bowel and bladder. On 6/15/06 at 1:30 pm, the resident's family member was interviewed and indicated that the resident was awakened on night shift (approximately 4 am) and was dressed for the day in bed but was not gotten up in her wheelchair until day shift arrived (approximately 6 am). The family member had just recently discovered this fact, but was told by staff that was	F 241		

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F 241	Continued From page 17 something they "always do." The family member was very upset by this action and stated, "I don't understand how they can do that." On 6/16/06 at 6:30 am, a CNA was observed to enter the resident's room and the surveyor followed. Resident #14 was observed lying in her bed fully clothed except for shoes. A clean and folded incontinent brief was observed on the bed side table. The CNA was asked when the resident was dressed for the day and the CNA responded, "I think it was about 10 minutes ago." However, the CNA was then observed to change the resident's incontinent brief. The brief was soiled and a date of 6/16/06 was on the brief, but there was no time indicated. The CNA proceeded to change the resident and with assistance of another CNA, transferred the resident to her wheelchair. The CNA was asked what time the resident usually got up for the day and the CNA indicated she always assisted resident #14 first, so it was around the same time each morning (6:15 - 6:30 am). On 6/16/06 at 10:35 am, the DON was interviewed. At this time he was made aware of the observation where resident #14 was noted to be fully clothed in her bed prior to her incontinent brief being changed. The DON was informed the CNA indicated the resident had been dressed "about 10 minutes" prior. The DON then acknowledged that it was difficult to imagine that if the resident was just dressed 10 minutes prior, the staff would not have changed the resident's brief at that time instead of waiting and doing it a few minutes later. 2. Random resident #27 was admitted on	F 241		

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F 241	Continued From page 18 10/25/05 with diagnoses including dementia and glaucoma. The resident's most recent MDS, dated 4/02/06, indicated she was severely cognitively impaired and required extensive physical assistance of one staff member for personal hygiene. The resident was observed on 6/13/06 at 7:30 am, sitting in her wheelchair in the dining room. The resident had long hair on her chin. The hairs were approximately 1/2 inch in length. On 6/14/06 at 11:00 am, the resident was observed sitting in her wheelchair in the tv room. The resident had long hair on her chin. The hairs were approximately 1/2 inch in length. The resident was observed on 6/15/06 and 6/16/06 numerous times with long hairs on her chin. On 6/16/06 at approximately 10:30 am, a staff interview was conducted with the resident care manager regarding random resident #27's long facial hair. She stated that she wasn't sure whether the staff of the Special Care Unit had ever addressed her long facial hairs in the 5 months that she had been a resident of that unit. At approximately 11:00 am, the resident care manager brought to the surveyor the nursing notes and stated that there was no documentation that the facial hairs had ever been addressed. She did state that approximately a month prior to the survey that one of the nurses on the Special Care Unit had removed random resident #27's facial hairs and had failed to document this in the medical record. The facility had not ensured that her hygiene was complete to present her with a dignified	F 241		

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F 241	Continued From page 19 appearance. 3. On 6/13/06 at 6:55 am, a CNA was observed entering room 215 without knocking. There was a resident in the room in bed at the time. The CNA was observed to move things around in the room, and was not observed to announce her presence or address the resident in any way. At 7:00 am, another CNA entered the room without knocking or announcing their presence in any way. On 6/16/06 at 6:30 am, a CNA was observed to enter resident #14's room without knocking. The staff members observed to enter the resident's rooms without knocking and asking for permission to enter were not respecting the resident's right to privacy and dignity. This is a repeat deficiency from the annual recertification survey of 5/13/05.	F 241		
F 248 SS=D	483.15(f)(1) ACTIVITIES The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and medical record review it was determined the facility failed to provide an on-going program of activities designed to meet the interests and	F 248	It is the policy of Lacrosse Health and Rehabilitation Center to provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident.	7/24/06

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F 248	Continued From page 20 physical, mental, and psychosocial well being of each resident. The facility failed to ensure activities in accordance with a comprehensive assessment of the residents interests and functioning levels that were measurable. This was true for 3 of 18 sampled residents (#1, 5 and 11) Findings include: According to "Quality Care in the Nursing Home," copyright 1997, pages 444 - 445, "Activities are important in the lives of nursing home residents. They are a source of pleasure and provide opportunities for positive engagement. They can invoke smiles, rekindle meaningful roles, lessen a dysphoric mood, strengthen self-identity, and alter physiology...activities must be seen as a central, driving force in the resident's daily life and plan of care..." 1. Resident #5 was admitted to the facility on 5/28/03 with diagnoses of fractured humerus, syncope, hypertension and dementia. The quarterly MDS dated, 4/19/06 identified resident #5 for the following: "Memory- a. short term memory problem; b. long term memory problem...Memory recall ability: staff names/faces...Cognitive Skills for daily decision making: moderately impaired-decisions poor; cues/supervision required...Average time involved in activities: Some-from 1/3 to 2/3 of the time." On 6/13/06 at 7:00 am, 7:30 am, 8:00 am, 8:30 am, 9:00 am and 10:00 am, resident #5 was observed sleeping on her bed in her room. On 6/13/06 at 11:00 am, resident #5 was observed wandering in the halls on the Special Care Unit. On 6/14/06 at 5:50 am, 6:30 am and 7:15 am,	F 248	The activity care plans for residents # 1, 5, and 11 have been rewritten and updated to reflect preferences. Interventions were put into place that are appropriate and reflect the assessment and activity participation flow sheets. The activity care plans and flow sheets for all other residents in the facility have been reviewed and updated if needed to properly reflect the needs of each resident. To enhance currently compliant operations and under the direction of the Administrator, the Activity Director will be inserviced regarding the need for the care plan to properly reflect the residents' needs and appropriate programming implemented to meet those needs. Activity care plans for each resident will be reviewed by the interdisciplinary team for accuracy each time a MDS assessment is due. The Clinical Reimbursement Coordinator will audit the MDS assessment and care plan to ensure they correctly reflect the needs of each resident. The Administrator will perform random bi-monthly audits to ensure activity participation matches the flow sheets. The audits will be forwarded to the quality assurance committee for review or corrective action.	

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F 248	Continued From page 21 resident #5 was observed sleeping on her bed in her room. On 6/14/06 at 8:15 am, she was observed eating breakfast in the dining room on the Special Care Unit. Resident #5 was not observed to take part in any organized activities during the survey. She was observed while awake continually pacing on the Special Care Unit. On 6/15/06 during a staff interview with the resident care manager, the resident care manager stated that resident #5 generally slept through breakfast. She stated that resident #5 spent most of her time wandering on the unit. She went on to report that resident #5 was difficult to redirect when engaged in behaviors that were not appropriate. The "Care Plan for Activity Pursuit" for resident #5 dated 8/05 stated, "...Cognition: dementia. Communication: clear. Behavior: agitated." The goal for the resident was, "Resident will participate in group 5 x [times] per week." The review date for the goal was 8/06. The approaches/interventions were: "Offer activities as preferred: cards, games, crafts, exercise, trips..." Review of resident #5's "Activities Calendar" revealed that her activity care plan goal of attending 5 groups per week were not met on the following weeks: the 2nd week of April; the 1st week of May; the 2nd week of May, the 3rd week of May, the 4th week of May, the 5th week of May and the 1st week of June. On 6/13/06 at approximately 10:00 am, a staff interview was conducted with the activities director regarding resident #5's activity care plan.	F 248		

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She stated that when she was obtaining copies of the activity calendars for resident #5 she realized that the facility was not being successful in providing activities for resident #5. She stated that she would be meeting with the activity team to define how to meet resident #5's activity needs.

The facility did not meet resident #1's activity care plan goal of participating in 5 group activities per week.

2. Resident #11 was admitted to the facility on 11/11/03 with diagnoses of dementia with psychotic features, osteoarthritis and abdominal aortic aneurysm.

The quarterly MDS dated, 4/16/06 identified resident #11 for the following: "Memory- a. short term memory problem; b. long term memory problem...Memory recall ability: location of room, staff names/faces and that he is in a nursing home....Cognitive Skills for daily decision making: moderately impaired-decisions poor; cues/supervision required...Average time involved in activities: Some-from 1/3 to 2/3 of the time."

On 6/13/06 at 6:50 am, 7:30 am, 8:20 am, 9:05 am, 9:35 am, 10:00 am, 11:25 am, 12:30 pm, 1:05 pm, and 1:30 pm, resident #11 was observed sleeping on his bed in his room. On 6/14/06 at 5:37 am, 6:05 am and 7:00 am, resident #11 was observed sleeping on his bed in his room. During an interview with the surveyor on 6/13/06 at 7:30 am, resident #11 stated that he did not wish to converse with the surveyor and that he refused any further visits during the survey. Resident #11 was observed out of his room self propelling his wheel chair on 6/15/06 at

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F 248	Continued From page 23 10:15 am. The Care Plan for Activity Pursuit dated 11/05 documented, "...Cognition: confused and alert. Communication: clear. Physical function: self propels." The goal for the resident was, "Will accept and partake in 1:1 visits 4 x [times] weekly." The review date for this goal was 2/06; 5/06 and 7/06. The approaches/interventions were: "...One to One activities: will accept and partake in 1:1 visits 4 x weekly." Activities Progress notes dated 1/11/05 stated, "...resident does continue to except [accept] 1:1 visits from activity staff. Will continue to monitor for concerns. Notes dated 2/08/06 stated, "...is excepting [accepting] of activity staff and will partake in 1:1 visits..." Notes dated 4/12/06 state, "...is excepting of activity visits. Care plan will remain effective will continue to monitor..." Review of the April 2006 "Activities Calendar" revealed that resident #11 was visited in his room for 1:1 visits on April 1, 2 and 3. The month of May 2006 resident #11 had 1:1visits on May 16 and May 25. The month of June 2006 resident #11 had a 1:1 visit on June 13th. On 6/16/06 at approximately 10:30 am, a staff interview was conducted with the activities director regarding resident #11's activity care plan. She stated that after making copies for the surveyor on the previous day she realized that the facility was not being successful in providing activities for resident #11. After review of the assessment and the activities progress notes she stated that she would be meeting with the activities team to define ways to meet resident	F 248		

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F 248	Continued From page 24 #11's activities needs. The facility failed to meet resident #11's activity care plan goal of being offered 1:1 visits four times per week. 3. Resident #1 was admitted to the facility on 03/24/06 with diagnoses of dehydration, dementia and pneumonia. The Medicare 30 day assessment MDS dated, 4/20/06 identified resident #1 for the following: "Memory- a. short term memory problem...Memory recall ability: location of own room....Cognitive Skills for daily decision making: moderately impaired-decisions poor; cues/supervision required....Average time involved in activities: Some-from 1/3 to 2/3 of the time." On 6/13/06 at 7:00 am; 7:45 am, 8:30 am, 10:00 am, 11:00 am, resident #1 was observed sleeping in his bed. On 6/13/06 at 12:30 am, the resident was observed in the dining room eating lunch. On 6/13/06 at 1:30 pm and 2:30 pm, resident #1 was observed lying on his bed. On 6/14/06 at 5:30 am, 7:30 am, 9:00 am, 10:30 am, 11:30 am and 1:30 pm, the resident was sleeping in his bed. On 6/13/06 at approximately 9:30 am, a staff interview was conducted with the resident care manager regarding resident #1's daily activities. She stated that,"resident #1 pretty much just does what he wants to do. He sleeps in most mornings and eats breakfast in his room and then goes back to sleep. He does not participate in many activities. He spends considerable amounts of time sleeping on his bed."	F 248		

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F 248	Continued From page 25 The "Care Plan for Activity Pursuit" dated 3/06 documented, "...Communication related to dx [diagnosis]/condition: clear. Physical function related to dx/condition: ambulatory. Mood related to dx/condition: fair." The goal for the resident stated, "Will participate in group activities: 5 x [times] per week." The review date for the goal was 6/06. The approaches/interventions were: "...Music: all kinds. Watching TV: old shows. Talking or conversing: peers, family and staff." The "Recreation History and Assessment" dated 3/24/06, identified resident #1's preferred activity setting as "his own room." Under mobility it stated, "needs assistance and wheelchair." Attitude towards activities, "uninterested." The initial interview summary, recreation plan and goals stated, "...is ambulatory able to make some needs known. Will complete care plan and monitor for concerns." A note dated 4/04/06 stated, "Resident remains able to ambulate. Expresses some needs. Will encourage and monitor." Activities Progress notes dated 4/10/06, documented, "...Resident #1 is adjusting to placement on the unit-family is supportive. Care plan has been completed. Will encourage and monitor for concerns." The notes for 4/25/06 stated, "Resident is ambulatory about the Special Care Unit. Is able to verbalize needs..." The April 2006 "Activities Calendar" revealed that resident #1 attended group activities on: April 2, April 4 and April 10. The May 2006 "Activities Calendar" revealed that resident #1 attended group activities on: May 1, May 5, May 7, May 15,	F 248		

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F 248	Continued From page 26 May 17, May 22 and May 27. The June 2006 "Activities Calendar" revealed that resident #1 attended group activities on: June 1, June 2, June 4, June 5, June 12 and June 13. On 6/13/06 at approximately 9:45 am, a staff interview was conducted with the activities director regarding resident #1's activity recreation history and assessment, and care plan. The surveyor pointed out the discrepancies in the recreation history and assessment regarding resident 1's ambulation, morning sleeping pattern and interest in activities. The activities director was very surprised to see the conflicting information. She stated that she had originally completed the form and was unsure who might have added additional information to it. When discussing resident #1's care plan, she stated that after making copies of the care plan for the surveyor she realized that the facility was not being successful in providing activities for resident #1. She stated that she would be meeting with the activity team to define how to meet resident #1's activity needs. The facility failed to meet resident #1's activity care plan goal of participating in 5 group activities per week.	F 248		

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F 252 SS=E	483.15(h)(1) ENVIRONMENT The facility must provide a safe, clean, comfortable and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews it was determined the facility failed to provide a comfortable and homelike environment. This affected 1 of 18 sampled residents (#12) and the 24 residents who ate in the dining rooms on the Special Care Unit when the following occurred: a. Housekeeping was observed hanging drapes in the dining room on the Special Care Unit during the lunch meal. b. An operational toilet was visible to all who entered the small dining room on the Special Care Unit. c. A resident's room did not have any personal affects present. 1. On 6/14/06 at approximately 12:10 pm, there were 10 residents sitting in the large dining room on the Special Care Unit. There was one staff present in the dining room in the process of distributing and setting up lunch trays for the residents. Two housekeeping personnel entered the large dining room. They had a clean drape and a small ladder with them. They went over to the far wall where there was a circular table against the wall in front of a window with only one drape on it. The circular table was set with drinks and napkins for 3 residents with 2 residents sitting	F 252	It is the policy of Lacrosse Health and Rehabilitation Center to provide a safe, clean, comfortable and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. The cited practice has the potential to affect all the residents on the special care unit. The housekeeping staff will be in-serviced on providing a comfortable and homelike environment and to refrain from doing work in the dining rooms during meal times. The privacy curtain shielding the toilet will be replaced with a door. Resident #12's room has been decorated to make it a more homelike environment. To enhance currently compliant operations and under the direction of the Social Services Director the social services assistant and activity department were in-serviced on the importance of providing a comfortable and homelike environment. All other areas of the facility have been inspected to ensure a homelike environment.	7/24/06

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F 252	Continued From page 28 at it. One of the housekeeping personnel removed one end of the drapery rod from the wall and proceeded to restring the drapery onto the rod. The surveyor observed that the drape that was hanging on the rod came down and touched one of the residents that was sitting at the table. At approximately 12:20 pm, the housekeeping personnel completed stringing the drapery and rehung the drapery rod on the wall. During this time there was still only one staff member present in the dining room with 10 residents. Housekeeping hanging drapes in the dining room during lunch is not a comfortable and homelike environment. 2. The Special Care Unit has two dining rooms. The smaller dining room is a resident room that is being used as a dining room. The room had 1 table for four residents and another table for 3 residents. Off to the left in that dining room was a triangular shaped room with an operational white toilet in it. There was no door on this room instead there was a hanging curtain that could be pulled shut. During all observations on 6/12/06, 6/13/06, 6/14/06, 6/15/06 and 6/16/06, the curtain was open with the toilet visible to all entering the room. Having a toilet in the dining room is not a comfortable and homelike environment. 3. Resident #12 was admitted to the facility on 1/22/04 with the diagnoses of dementia, schizophrenia, depression, hypothyroidism, and thrombocytosis. The resident's most recent quarterly MDS, dated 4/13/06, documented the resident required extensive to total assistance of one staff or two staff for transfers, ambulation,	F 252	Monthly rounds will be performed by social services and activities to determine if any other residents' rooms lack personal effects. Areas of concern will be fixed promptly with audit results reviewed by the quality assurance committee.	

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F 252	Continued From page 29 toileting, dressing and personal hygiene. The resident's "Care Delivery Guide" dated 4/13/06, documented the resident required "assistance to activities" and "preferred to nap between meals and go to bed after supper." The resident's "Activity Pursuit Patterns Plan of Care" documented the resident enjoyed, "music, reading/writing, watching TV, the outdoors, and was Catholic." On 6/13/06 at 7:30 am, resident #12's room was observed. The walls on the resident's side of the room were bare and did not have any pictures or personal items to make the room more homelike and less institutionalized. The resident's bedside table was also bare and free of personalized touches. The resident's bed had one small stuffed animal on it. The resident's roommate had a TV that was located across the room and always observed at a very low volume. There was no radio, tape, or CD player observed on resident #12's half of the room. Resident #12's room was observed in this condition on 6/14 and 6/15/06. On 6/15/06 at 9:05 am, one of the facility's social workers was interviewed. At this time they were asked if resident #12 had any active family members and they indicated she did not. The social worker was then asked what their department did if resident's families were not involved to bring in personal affects from home to help the rooms be more homelike. The social worker indicated that their department partnered with activities to try and add some items to the resident's room that correlated to their likes and activity interests. The social worker indicated that their department had used resident trust account	F 252		

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F 252	Continued From page 30 funds to purchase items (pictures, plants, etc) to also make the room more homelike. The social worker indicated she would look into what could be done to improve resident #12's room to make it more homelike. On 6/16/06 at 9:55 am, resident #12's room was observed. There were several items placed along the room that gave the resident's area of the room a more comfortable and homelike appearance. Resident #12 spent a good deal of time in her room. However, the facility did not ensure the resident's room was a comfortable and homelike environment. The resident's care plan indicated she enjoyed music, the outdoors and was Catholic. Her room did not contain any items that correlated to her identified interests.	F 252 F253	It is the policy of Lacrosse Health and Rehab to maintain a sanitary, orderly and comfortable interior. To enhance currently compliant operations and under the direction of the DON, on 7/11/06 the nursing assistants will receive in-service training regarding urinal maintenance and storage. All cited examples were corrected during the survey process. Because all residents are potentially affected by the cited deficiency, on 7/10/06, the DON made bathroom rounds and found no other examples of odors or urinals sitting on the back of toilets Effective 7/14/06, a quality-assurance program was implemented under the supervision of the DON to monitor for bathroom odors and misplaced urinals. The DON or designated representative will conduct random bathroom audits. Any deficiencies will be corrected on the spot, and the findings of the quality-assurance checks will be documented and submitted at the quality-assurance committee meetings for further review or corrective action.	7/24/06
F 253 SS=D	483.15(h)(2) HOUSEKEEPING/MAINTENANCE The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined the facility did not ensure resident's personal care equipment was maintained in a sanitary manner or ensure resident bathrooms were free of malodorous smells. This was true for 3 or 18 sampled residents (#'s 6, 10 and 12) whose environments were investigated. Findings include:	F 253		

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F 253	Continued From page 31 1. Resident #6 was admitted to the facility on 7/14/05 with the diagnoses of dementia, macular degeneration, angina, depression, and hypothyroidism. On 6/13/06 at 6:45 am, the resident's bathroom was observed and a very strong urine odor permeated the bathroom. There was also an empty, clean urinal stored on the back of the toilet. There was no identifying information on the urinal to determine who it belonged to. There were no male residents in either of the two rooms with the connecting bathroom. The bathroom was observed again on 6/14/06 at 7:50 am and 2:30 pm, and a strong urine odor was noticed. The clean urinal was still stored on the back of the toilet. On 6/15/06 at 8:40 am, resident #6's bathroom was found with the same strong urine smell and the empty urinal on the back of the toilet. 2. a. Resident #10 was admitted to the facility on 4/20/04 with the diagnoses of pneumonia, pulmonary fibrosis, dementia, depression and anxiety. On 6/13/06 at 8:15 am, the resident's bathroom was observed to have a urinal located on the back of the toilet. A resident's name was written on the urinal and was the resident whose room was next to resident #10. The urinal was observed to have dried urine in the bottom. There was a definite odor of urine coming from the urinal, but it did not permeate the rest of the bathroom. The urinal was again observed in the same condition and location on 6/13/06 at 1:32 pm, 6/14/06 at 7:50 am and 12:10 pm.	F 253		

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F 253	Continued From page 32 b) Resident #12 was admitted to the facility on 1/22/04 with the diagnoses of dementia, schizophrenia, depression, hypothyroidism, and thrombocytosis. Resident #12 was the roommate to resident #10 and the above observations of the dirty male urinal in the resident's bathroom also apply to this resident. On 6/15/06 at 8:45 am, the DON was informed of the dirty urinal in resident #10 and 12's bathroom, and the empty clean urinal in resident #6's bathroom. The DON was also notified of the strong urine odor in resident #6's bathroom. The DON acknowledged that both male residents in the room next to resident # 10 and 12's room used urinals and that they should be cleaned and stored appropriately. The DON indicated he would check into the matter. The DON also acknowledged that only female residents were in resident #6's room and the adjacent room which shared the bathroom, and was not sure what the urinal would be doing there. He indicated he would have the maintenance department look into the strong urine smell. The DON did not get back with the surveyor as to the results of the inquiry into the urinals and the strong urine smell. This is a repeat deficiency from the annual recertification survey of 5/13/05.	F 253		

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F 272 SS=E	483.20, 483.20(b) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the RAI specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed through the resident assessment protocols; and Documentation of participation in assessment. This REQUIREMENT is not met as evidenced by: Based on record review, observations and staff interview, it was determined the facility did not ensure resident assessments were accurate, comprehensive and ongoing in the areas of skin	F 272	It is the policy of Lacrosse Health and Rehab to conduct a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. To enhance currently compliant operations and under the direction of the DON, during the weeks of 7/10/06 and 7/17/06 each RCM will re-evaluate each resident's urinary, skin, fall risk and side rail assessments and plans of care. A 3-day voiding pattern assessment, a Bladder Data Collection and Assessment and an Alteration in Urinary Continence Plan of Care will be re-done for all residents. All residents with indwelling urinary catheters will be re-evaluated for appropriateness of continued use. The licensed staff/ RCMs will be in-serviced on 7/13/06 concerning bladder assessments after catheters are discontinued, utilizing a 3-day voiding pattern, and conflicting data between various assessments. Skin Integrity Assessment: Prevention and Treatment Plan of Care will be re-evaluated for all residents. Those residents with ulcers will have their Skin Grid weekly documentation forms reviewed and revised as needed. The licensed nurses will be in-serviced on 7/13/06 regarding documentation issues concerning Admission Skin Assessments, Skin Integrity Plan of Care and the Skin Grid.	7/24/06

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F 272	Continued From page 34 integrity, fall risk, safety of side rails and bladder function. This was true for 11 of 21 sampled residents (#'s 1, 3, 5, 6, 7, 12, 13, 15, 17, 19, and 21). Findings include: Bladder Assessment: 1. Resident #19 was admitted to the facility on 1/6/06 with the diagnoses of multiple sclerosis (MS), aspiration pneumonia, dysphagia and neuralgia. Resident #19 was admitted with a Foley catheter for urinary retention related to a MS flare up. The resident's "Bladder Data Collection and Assessment" form, dated 1/11/06, documented the resident had a Foley catheter related to urinary retention. The section provided to determine the appropriate retraining or maintenance program for the resident was left blank. A physician's telephone order to discontinue the Foley catheter was obtained for resident #19 on 1/13/06 and read, "D/C [discontinue] Foley in am 1/14/06 if unable to void spontaneously after 6 hrs [hours], do I/O [input/output] cath[erarization]. Do I/O cath Q [every] 8 [hours] prn [as needed] bladder discomfort." The resident remained at the facility until 3/8/06. There was no bladder assessment found after the resident's catheter was discontinued on 1/14/06 to determine the best program to maintain or improve the resident's bladder function. On 6/16/06 at 10:40 am, the DON was	F 272	All residents utilizing side rails will be re-evaluated for their appropriateness and safe use. The documentation concerning the assessment for safe side rail use will be placed on the Physical Restraint/Enabler Assessment in the resident's medical record. The licensed staff/RCMs will be in-serviced on 7/13/06 concerning the documentation of side rail safety. Fall/Injury Assessment: Prevention and Management Plan of Care will be reviewed and revised as necessary for all residents. The licensed staff/RCMs will be in-serviced on 7/13/06 concerning the updating of care plans to reflect the residents current status. Because all residents are potentially affected by the cited deficiency, the above reviews and re-assessments will be performed on all facility residents. Effective 7/21/06, a quality-assurance program will be implemented under the supervision of the DON to monitor the completion and appropriateness of resident assessments. The DON or designee will perform random audits of resident medical records for assessment completion, appropriateness and updates as necessary. Any deficiencies will be corrected on the spot, and the findings of the quality-assurance checks will be documented and submitted at the quality-assurance committee meeting for further review or corrective action.	

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F 272	Continued From page 35	F 272		

interviewed and asked to provide a bladder assessment after the resident's catheter was discontinued. No assessment was provided. No explanation or rational was offered as to why a bladder assessment was not completed after the d/c of the catheter.

2. Resident #21 was admitted to the facility on 1/26/06 with the diagnoses of cerebral vascular accident, chronic aspiration pneumonia hypertension, hypothyroidism and a history of compression fractures.

A "Patient Referral" form from the transferring hospital, dated 1/26/06, documented the resident was admitted to the facility with a catheter. An undated nursing assessment form documented under the "Genitourinary" section, "Catheter: yes, Foley."

Resident #21's "Bladder Data Collection and Assessment" dated 1/30/06, documented the resident had functional incontinence related to "mobility/manual dexterity impairments." This assessment also documented, "has foley cath - no sensation of need to use toilet." The section provided to determine the appropriate retraining or maintenance program for the resident was left blank.

A "Physician's Telephone Order" dated 4/3/06, documented "D/C Foley Cath if ok [with] nursing staff..." The resident remained at the facility until 4/27/06.

There was no bladder assessment found after the resident's catheter was discontinued on 4/3/06 to determine the best program to maintain or

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F 272	Continued From page 36 improve the resident's bladder function and prevent urinary tract infections. On 6/16/06 at 10:40 am, the DON was interviewed and asked to provide a bladder assessment after the resident's catheter was discontinued. No assessment was provided. No explanation or rational was offered as to why a bladder assessment was not completed after the d/c of the catheter. 3. Resident #12 was admitted to the facility on 1/22/04 with the diagnoses of dementia, schizophrenia, depression, hypothyroidism, and thrombocytosis. The resident's most recent quarterly MDS, dated 4/13/06, documented the resident required extensive to total assistance of one staff or two staff for transfers, ambulation, toileting, dressing and personal hygiene. This assessment indicated the resident was frequently incontinent of bowel and bladder. The resident's quarterly MDS, dated 2/9/06, indicated the resident required the same amount of assistance, but documented the resident was usually continent of bladder (one episode or less a week) and totally continent of bowel. Resident #12's "Bladder Data collection and Assessment" dated 2/3/06, documented the resident was incontinent related to "mobility/manual dexterity impairments, dementia." The type of incontinence was determined to be "functional," and the resident was placed on a "scheduled check and change program." The form indicated residents, "who cannot sit on toilet/commode may be a candidate" for use of this program. This assessment concluded the resident was not a candidate for	F 272		

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F 272	Continued From page 37 bladder retraining, prompted voiding or scheduled toileting. There was no documentation on this assessment that indicated a voiding pattern was determined. This bladder assessment information did not correlate to the MDS data on continence status completed in the same week. The resident's "Skin Integrity Assessment" dated 11/11/05 and updated on 4/13/06, documented a risk factor of "moisture." Under this by "Incontinence: Urine," the hand written word, "Rarely" was documented. The assessment of resident #12's continence status was conflicting between the bladder assessments, the resident's MDS data, and the skin integrity assessment. No documentation was found that a voiding schedule/pattern was done to determine the most appropriate toileting program for this resident. Skin Assessments: 1. Resident #15 was admitted to the facility on 11/3/05 with diagnoses which included cerebrovascular accident (CVA) with left sided weakness, hypertension, and depression. According to the resident's admission MDS assessment, dated 11/13/05, the resident was identified as having modified independence with cognitive skills for daily decision making, required extensive assistance with bed mobility, transfers, dressing, toilet use and personal hygiene. No skin ulcers or history of resolved ulcers were identified. Review of the admission skin assessment, dated	F 272		

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F 272	Continued From page 38 11/3/05, revealed no skin breakdown on the resident's buttocks area. Further review of the resident's record revealed a quarterly nursing assessment (photocopied at the facility the afternoon of 6/15/06), dated 4/17/06. The nursing assessment revealed no documentation regarding a skin assessment or any breakdown in the resident's skin. On 6/15/06 at 1:15 pm, resident #15 and her family member were interviewed. The resident and the family member stated they were concerned about the resident's skin on her buttocks area. The family member stated the resident had a sore on her buttocks area since October of 2005 and it had been on-going since. The family member stated the resident had not been turned and repositioned as needed during the night and was concerned that the sore was not healing. On 6/16/06 at 10:20 am, resident #15 consented to have the surveyor observe her skin on her buttocks, only while she was being transferred to the toilet by the aid of a CNA. Due to the brief observation, the following was observed by the surveyor: a large reddened area encompassing both sides of the resident's buttocks measuring approximately 6 to 7 inches in diameter. Inside of the reddened area along the line delineating each side of the buttocks, were two dark purple areas approximately the size of an egg. On 6/16/06 at 10:45 am, the Resident Care Manager (RCM) was interviewed. The RCM was informed of the surveyor's observation of the resident's skin. The RCM stated that the	F 272		

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F 272	Continued From page 39 resident's skin had been discolored for a long time and stated the resident had refused at times to have her incontinence briefs changed during the night. At that time, the surveyor requested any documentation and/or assessments of the resident's skin and informed the RCM that no documentation could be located previously about the resident's skin. The RCM showed the surveyor the admission skin assessment and acknowledged that it did not indicate any skin breakdown on the resident's buttocks, but stated she would look for any further assessments or documentation regarding the resident's skin and refusals. On 6/16/06 at 12:00 pm, the RCM provided documentation of the same quarterly nursing assessment, dated 4/17/06, which documented, "Hx [history] recurrent yeast rash & [and] of Stg [stage] II PU [pressure ulcer] Rt [right] buttock skin on buttocks sl [slightly] discolored [no] open area." No further assessments or documentation about the resident's skin or refusal of care was received. 2. Resident #17 was admitted to the facility on 5/23/06, with diagnoses which included Alzheimer's dementia. According to the resident's admission MDS assessment, dated 6/1/06, the resident was moderately impaired with cognitive skills for daily decision making, and required extensive assistance with bed mobility, transfers and dressing. The assessment also indicated the resident had a Stage II pressure ulcer. According to the resident's admission skin	F 272		

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F 272	Continued From page 40 assessment, dated 5/23/06, the resident had a "Bandaged L [left] heel" and indicated to "See Skin Grid - Pressure/Stasis Ulcer/Other." Review of the "See Skin Grid - Pressure/Stasis Ulcer/Other" form, dated 5/23/06, revealed documentation the resident was admitted with a Stage II pressure ulcer to the left heel. The resident's "Skin Integrity Assessment: Prevention and Treatment Plan of Care" dated 5/23/06, documented the resident was at risk related to: "Bowel Incontinence; Bladder Incontinence..." There was no documentation on the assessment related to the resident's decreased mobility or the resident's Stage II pressure ulcer. On 6/16/06 at 7:00 am, the DON was interviewed regarding the lack of documentation in the resident's skin at risk assessment regarding the resident's history of a Stage II pressure ulcer or the lack of documentation in the assessment regarding the resident's impaired/decreased mobility. He stated he would try to locate documentation regarding those areas. On 6/16/06 at approximately 9:00 am, the DON provided the surveyor a revised "Skin Integrity Assessment: Prevention and Treatment Plan of Care" dated 6/15/06, on which was documented, "At risk related to: Impaired/decreased mobility and decreased functionality: (describe) r/t [related to] SDAT [senile dementia Alzheimer's type]." Under "Skin: (describe)...Open Areas: Stage II Location Left heel; abrasion right calf (6/16/06); scab left calf (6/16/06)..."	F 272		

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F 272	Continued From page 41 3. Resident #1 was admitted to the facility on 03/24/06 with diagnoses of dehydration, dementia and pneumonia. Resident #1 had two conflicting "Admission Skin Assessment" forms completed in his chart. One "Admission Skin Assessment" form dated 3/24/06 was signed by the RCM. The only skin issue that this form documented was a Stage II pressure ulcer on resident #1's coccyx. A second "Admission Skin Assessment" in resident #1's chart that was not dated did not document the Stage II pressure ulcer. The second "Admission Skin Assessment" did document the following skin issues for resident #1: 4 cm by 5 cm bruise on his left inner forearm; 1 cm by 4 cm scar on the inner biceps area of the residents left arm; a red dot on the top of his left foot by his little toe; a small red mark in the upper middle part of the resident's back and a 2 cm scar about 3 inches lower in the middle section of his back. The nurses notes dated 3/24/06 at 5:00 pm, documented, "...Stage II to coccyx with hydrocolloid-dressing in place. On admit numerous bruises to right and left arms from IV start..." The Medicare 5 day MDS dated 3/24/06, documented under "Ulcers: Stage 2-one." "Other skin problems or lesions present: Abrasions, bruises." Review of the "Skin Integrity Assessment: Prevention and Treatment Plan of Care" dated 3/24/06, documented that resident #1 had a Stage II pressure ulcer on his coccyx, however, it did not document any of the other skin issues that	F 272		

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F 272	Continued From page 42 the resident had upon admission. On 6/14/06 at 9:00 am, a staff interview was conducted with the RCM of the Special Care Unit regarding the "Admission Skin Assessment" forms for resident #1. She was confused as to how there could be two conflicting forms. She stated that she had completed the one documenting the Stage II pressure ulcer and the other assessment was completed by a nurse who was no longer employed by the facility. 4. Resident #6 was admitted to the facility on 7/14/05 with the diagnoses of dementia, macular degeneration, angina, depression, and hypothyroidism. The resident's most recent quarterly MDS, dated 5/11/06, documented the resident required extensive assist of two staff for bed mobility, transfers, toileting and personal hygiene. Resident #6's Pressure Ulcers RAP from an annual MDS, dated 12/5/05, documented "....Had a stage two which has now healed...No longer feels pain or pressure." A "Skin Grid -Pressure/Venous Insufficiency Ulcer" sheet for resident #6 documented that on 10/27/05, resident #6 developed a stage II pressure ulcer on her coccyx that measured "0.5 cm [centimeters] in length, 0.5 cm in width, and 0.2 cm in depth." The resident's "Skin Integrity Assessment/Care Plan" dated 12/8/05, was reviewed. Page 4 contained an area to document "history of healed ulcer" that was left blank. There was no documentation on this assessment that discussed or indicated the resident had a decreased ability to feel pain or pressure as indicated on the	F 272		

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F 272	Continued From page 43 resident's pressure ulcer RAP. This assessment for skin impairment was incomplete and did not include all necessary information to ensure all risk factors were addressed and care planned interventions put in place. On 6/15/06 at 8:45 am the DON was interviewed and acknowledged the resident's history of a healed stage II pressure ulcer was not on the current skin integrity assessment. Side Rail Assessments: 1. Resident #13 was admitted to the facility on 4/11/05 with diagnoses of hypertension, atrial fibrillation and muscle weakness. On 6/13/06 at 6:30 am, resident #13 was observed in her bed with both 1/2 side rails raised and an overhead trapeze. In resident #13's medical record there was a "Physical Restraint/Enabler Assessment" signed by the resident and facility staff on 4/10/06. There was no documention on the form that the facility had assessed resident #13 as safe in using the 1/2 side rails and the overhead trapeze. On 6/14/06 at 3:00 pm, a staff interview was conducted with the resident care manager regarding the assessment of safety for resident # 13. The resident care manager stated, "I personally completed the safety assessment. I visually assessed the safety of the side rails for resident #13." The resident care manager admitted that she had not documented the safety	F 272		

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F 272	Continued From page 44 assessment in the resident's chart. 2. There were similar findings for resident #3 who utilized 1/2 side rails bilaterally for repositioning. The "Physical Restraint/enabler Assessment," dated 12/12/05, and reviewed on 3/13/06 and again on 5/16/06, did not indicate the resident was assessed for safety in side rail use. Fall Assessments: 1. Resident #7 was admitted to the facility on 4/14/06 with the diagnoses of congestive heart failure, asthma, chronic obstructive pulmonary disease, dementia and status post femur fracture. The resident's admission MDS, dated 4/24/06, documented the resident required extensive assistance of one staff for bed mobility, transfers and toileting and was moderately cognitively impaired. The resident's Falls RAP, dated 4/24/06, documented "res[ident] had a fall at home. res is alert and able to make needs known...Res has a L [left] hip fx [fracture]. Res does work with therapies. Will not care plan at this time." Resident #7's Fall/Injury Assessment/Care Plan" dated 4/14/06, documented the resident had a "hx [history] of fall/Injury [at] home [with] hip fx." This assessment indicated the resident was confused related to dementia. This assessment did not indicate the resident had any falls at the facility. Nor did it indicate the resident had poor safety awareness and often tried to self transfer or ambulate on a reduced weight bearing status. Resident #7's "Care Delivery Guide," dated	F 272		

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F 272	Continued From page 45 5/4/06, documented the resident was a "High Fall Risk" and had "[no] safety skills." This form also documented under "safety," "Cue to WB [weight bearing] status. Does not remember [decreased] WB status - tries to stand." Review of the facility's "Accident/Incident Reports" revealed resident # 7 had falls on 5/5, 5/8, 5/12, and 5/31/06 related to trying to ambulate or stand unassisted. The resident's "Problem Oriented Progress Notes" were reviewed from 4/14/06 through 6/13/06 and found many entries that documented the resident was very confused, showed disregard for safety, and made multiple attempts to stand or ambulate unassisted. These notes also documented the resident needed "frequent reminders" for assistance and needed "supervision." However this identified information was not documented on the resident's assessment for safety and to prevent falls in order to adequately care plan and implement interventions to prevent falls and/or injuries. The assessment that was completed on the date of admission did not accurately assess the resident's condition related to falls. On 6/15/06 at 8:45 am, the DON was interviewed and acknowledged the resident's falls at the facility and decreased safety awareness was not on the current fall risk assessment. 2. Resident #5 was admitted to the facility on 5/28/03 with diagnoses of fractured humerus, syncope, hypertension and dementia. The "Fall Assessment: Prevention and	F 272		

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F 272	Continued From page 46 Management Plan of Care" completed on 8/17/05 did not document that resident #5 had a history of falls even though the resident was admitted to the facility with a fractured humerus as a result of a fall per conversation with resident care manager on 06/15/06 at 11:00 am. The resident care manager also stated that upon admit to the facility, the resident had three bruises, two scabs and three scrapes due to her fall history. Based on review of the facilities incident and accident reports, the "Fall Assessment: Prevention and Management Plan of Care" was not updated to reflect that the resident had a history of falls until after her third fall in the facility on 5/21/06. There was no Fall Risk Scale Form in the chart that assessed the resident based on history, in order to assist the facility in planning for risk of falls for the resident.	F 272		

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F 279 SS=E	483.20(d), 483.20(k)(1) COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on record review, observations and staff interview, it was determined the facility did not ensure resident care plans were comprehensive to address all assessed risk factors and did not contain specific information or instruction in the areas of skin integrity, fall risk and bladder function. This was true for 6 of 21 sampled residents (#'s 4, 6, 12 and 14). Findings include: 1. Resident #4 was admitted to the facility on 8/16/05 with diagnoses which included Alzheimer's disease, coronary artery disease, history of myocardial infarction, and degenerative	F 279	It is the policy of Lacrosse Health and Rehab to develop a comprehensive care plan for each resident. To enhance currently compliant operations and under the direction of the DON, during the weeks of 7/10/06 and 7/17/06 each RCM will re-evaluate each incontinent resident's urinary assessment and plan of care. A 3-day voiding pattern assessment, a Bladder Data Collection and Assessment and an Alteration in Urinary Continence Plan of Care will be re-done for all incontinent residents. Clearly stated interventions will be incorporated into each residents care plan. The cited residents care plans have been updated with specific interventions for direct care staff. The nursing assistants will be in-serviced on 7/11/06 defining "routinely" as every two to three hours. Because all residents are potentially affected by the cited deficiency, the above reviews and re-assessments will be performed on all incontinent residents.	7/24/06

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	135042	A. BUILDING _____ B. WING _____	06/19/2006

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F 279	Continued From page 48 joint disease. The resident's admission MDS assessment, dated 8/26/05, indicated the resident was moderately impaired with cognitive skills for daily decision making, required extensive assistance of two staff persons for bed mobility and transfers, was incontinent of both bowel and bladder, and had partial loss of voluntary movement. The assessment also indicated the resident had one Stage II pressure ulcer. Review of the resident's record revealed a "Skin Integrity Assessment: Prevention and Treatment Plan of Care", revised 5/25/06, indicating the resident was at risk related to: "Impaired/decreased mobility and decreased functionality: DJD [degenerative joint disease], Dementia...Co-morbid Conditions: Bowel Incontinence, Bladder Incontinence...History of a healed ulcer..." The documented interventions included the following: "...Turning and Repositioning Program...Protect/elevate heels: float heels...Lay down between meals...assist to reposition prn [as needed]..." Review of the "Care Delivery Guide," dated 5/25/06, documented, "Bladder Incontinent briefs; Bowel Incontinent [check] routinely..." The care plan also revealed a problem, dated 5/25/06, which documented, "Bladder Incontinence (frequency): Incontinent." The listed interventions included: "...Provide adult: briefs; Change incontinent product PRN [as needed]: routinely..." The section regarding at which specific intervals during the day to provide assistance "based upon voiding pattern/incontinence" was left blank. On 6/14/06 at 2:00 pm, the resident's buttocks	F 279	Effective 7/21/06, a quality-assurance program will be implemented under the supervision of the DON to monitor the appropriateness and specificity of the care plans. The DON or designee will perform random audits of resident care plans for specific and measurable interventions. Any deficiencies will be corrected on the spot, and the findings of the quality-assurance checks will be documented and submitted at the quality-assurance committee meeting for further review or corrective action.	

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F 279	Continued From page 49 was observed with the RCM. The skin on both sides of the buttocks were reddened, but the areas were blanchable to touch. On 6/14/06 at 11:45 am, the RCM was interviewed regarding the lack of clearly defined interventions on the care plan. The RCM stated the resident was to be layed down between meals and to be toileted before and after meals and at bedtime, usually every 2 hours. The resident's care plan did not give measurable guidance to staff regarding how often to turn and reposition the resident or specify individualized interventions regarding toileting and incontinence care. 4. Resident #6 was admitted to the facility on 7/14/05 with the diagnoses of dementia, macular degeneration, angina, depression, and hypothyroidism. The resident's most recent quarterly MDS, dated 5/11/06 documented the resident required extensive assist of two staff for bed mobility, transfers, toileting and personal hygiene. This assessment also documented the resident was incontinent of bowel and bladder. The resident's Urinary Incontinence RAP summary, dated 12/8/05 documented, "...No longer recognizes the need to toilet and does not make needs known. Is a two person transfer. Wears briefs and is change {sic} routinely..." Resident #6's "Care Delivery Guide" dated 12/8/05, documented the resident was "incontinent" and was a "Routine [check] [and] [change]." The resident's "Skin Integrity Assessment: Prevention and Treatment Plan of Care" dated 12/8/06, documented under the identified problem of "Moisture: Incontinence:	F 279		

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F 279	Continued From page 50 Urine and Stool," with the following interventions, "Provide incontinent care: Routine D/E [day/evening] Overnight briefs [at] noc [night]. [Change] [at] 10:00 pm, 4:00/5:00 am." The resident's "Alteration in Urinary Continence/Plan of Care" dated 12/8/05, documented "Provide assistance at specific intervals during day based upon voiding pattern/incontinence...other: [change] routinely during shift." On 6/15/06 at 8:45 am, the DON was interviewed related to resident #6's toileting/incontinence care schedule. The DON was asked what "routinely" meant and he indicated the staff "tried" to change everyone every 2-3 hours. Resident #6's plan of care did not provide specific instructions when to provide incontinence care to the resident. The care plan directed to change the resident "routinely" but did not give specific time intervals or times of day to ensure the resident was maintained as dry as possible in order to prevent complications. 5. Similar findings were found for resident #'s 12 and 14. These residents were dependent on staff for toileting and were incontinent of bowel and bladder. The residents' care plans directed staff to provide incontinent care or brief changes "routinely." There were no specific instructions related to time intervals or times of day when these residents were to be provided care in order to ensure their skin was kept as dry as possible to prevent potential break down and to maintain the highest practical bladder function.	F 279		

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F 280 SS=D	483.20(d)(3), 483.10(k)(2) COMPREHENSIVE CARE PLANS The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review it was determined the facility failed to ensure the comprehensive care plans were periodically reviewed and revised after each assessment regarding each residents' refusals of care. This was true for 2 of 18 sampled residents (#'s 3 and 15). 1. Resident #3 was admitted to the facility on 11/8/01 and re-admitted on 6/20/04 with diagnoses which included diabetes mellitus with peripheral neuropathy, necrotic diabetic ulcer of the left foot, and osteomyelitis of the left foot. Review of the resident's record revealed a "Skin	F 280	It is the policy of Lacrosse Health and Rehab to develop a comprehensive care plan for each resident. To enhance currently compliant operations and under the direction of the DON, during the weeks of 7/10/06 and 7/17/06 each RCM will re-evaluate all residents with a history of refusing cares. The care plans will be updated to include alternative measures to utilize when a refusal occurs. This includes the two cited residents. The IDT members will be in-serviced by the DON on 7/14/06 concerning the need to specify alternatives when resident refusals occur. Because all residents that have a history of refusing certain cares are potentially affected by the cited deficiency, a review and revision of care plans as stated above will occur and be completed by 7/21/06. Effective 7/21/06, a quality-assurance program will be implemented under the supervision of the DON to monitor care plans for the inclusion of alternative measures to be utilized should a refusal of care occur. The DON or designee will perform random audits of resident care plans for specific and measurable interventions. Any deficiencies will be corrected on the spot, and the findings of the quality-assurance checks will be documented and submitted at the quality assurance committee meeting for further review or corrective action.	7/24/06

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F 280	Continued From page 52 Grid - Pressure/Venous Insufficiency Ulcer/Other" form, dated 2/21/06, on which was documented an initial site of a right lateral ankle skin ulcer assessed at a Stage II and described as being both a diabetic and pressure ulcer. Review of the resident's plan of care, updated 5/25/06, revealed a "Skin Integrity Assessment: Prevention and Treatment Plan of Care." On the interventions side of the form it was documented, "Protect/elevate heels: Encourage to float heels using bolster...Resident Refusal: Education, demonstrates understanding of noncompliance, encourage to allow tx or assessment of wounds/skin, Treatment: Monitor wound weekly and PRN..." A separate form, dated 12/4/05, indicated a problem of "Decreased functional status r/t [related to] neuropathy, stasis ulcer [left] ft [foot] chronic, Actual/Potential areas of concern: ADL's, Urinary, Fluids, DM [diabetes mellitus]." The documented intervention included, "...Float heels in bed - foot protector when OOB [out of bed]..." Review of the resident's record revealed treatment flowsheets for the months of April and May 2006 on which it was documented, "Weekly Skin Assessment by RCM (-) No new areas (+) new areas noted." On 4/5/06, 4/12/06, 4/19/06, 4/26/06, 5/2/06, 5/9/06, 5/15/06, 5/23/06 and 5/30/06, there was documentation of a LN's initials with a circle around them. On the back of the form it was documented the resident "refused skin rounds" for the listed dates. Observation of the resident on 6/13/06 at 7:00 am, revealed the resident sitting in his wheelchair. A protective boot was observed on his left foot.	F 280		

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F 280	Continued From page 53 However, there was no protective footwear observed on his right foot. The same observations were made on 6/13/06 at 10:25 am, 12:35 am, and 6/14/06 at 1:45 pm. On 6/14/06 at 11:45 am, the Resident Care Manager (RCM) was interviewed regarding the resident's refusals of treatments, skin assessments, and the lack of specific guidance in the resident's care plan regarding his refusals of treatments and assessments. She stated the resident refused to wear a foam boot to his right foot. The surveyor then repeated their request for supporting documentation regarding the resident's refusals. On 6/14/06 at 1:45 pm, the RCM stated that there was no current documentation in the resident's chart regarding the refusal of the protective boots or the refusal to float his heels. On 6/15/06 at 11:00 am, the RCM acknowleged that the resident was not wearing any protective footwear on his right foot. She reiterated that the resident did refuse for the LNs to assess his skin and to wear the protective footwear. The RCM provided the surveyor with a "Mood and Behavioral Symptom assessment/Plan of Care" dated 1/05. However, this care plan documented that the resident was at times in a "bad mood" and was at times inappropriate with staff. The care plan did not direct staff regarding the resident's refusals of treatments and assessments of his skin ulcers. According to federal guidance for F314 regarding the resident's care plan, "If the resident refuses or resists staff interventions to reduce risk or treat	F 280		

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F 280	Continued From page 54 existing pressure ulcers" the care plan must reflect the efforts of the facility to "seek alternatives to address the needs identified in the assessment." 2. Resident #15 was admitted to the facility on 11/3/05 with diagnoses which included cerebrovascular accident (CVA) with left sided weakness, hypertension, and depression. The resident's admission MDS assessment, dated 11/13/05, identified the resident as having modified independence with cognitive skills for daily decision making, and required extensive assistance with bed mobility, transfers, dressing, toilet use and personal hygiene. No skin ulcers or history of resolved ulcers were identified. Review of the admission skin assessment, dated 11/3/05, revealed no skin breakdown on the resident's buttocks area. Review of the resident's "Skin Integrity Assessment: Prevention and Treatment Plan of Care" dated 11/3/05, documented on the intervention side of the care plan, "...turning and repositioning program q 2° [hours] at noc [night] or noc rounds." On 12/20/05, it was documented, "Res[ident] refuses @ x's..." There was no further documentation regarding the resident's refusals of treatment or what alternative measures staff should follow. On 6/15/06 at 1:15 pm, resident #15 and her family member were interviewed. The resident and the family member stated they were concerned about the resident's skin on her buttocks area. The family member stated the	F 280		

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F 280	Continued From page 55 resident had a sore on her bottom since October of 2005, and it had been on-going since. The family member stated the resident had not been turned and repositioned as needed during the night, and was concerned that the sore was not healing. On 6/16/06 at 10:20 am, resident #15 consented to have the surveyor observe her skin on her buttocks only while she was being transferred to the toilet by the aid of a CNA. Due to the brief observation, the following was observed by the surveyor: a large reddened area encompassing both sides of the resident's buttocks measuring approximately 6 to 7 inches in diameter. Inside the reddened area along the line delineating each side of the buttocks, was two dark purple areas approximately the size of an egg. On 6/16/06 at 10:45 am, the RCM was interviewed. The RCM was informed of the surveyor's observations of the resident's skin. The RCM stated that the resident's skin had been discolored for a long time and the resident had refused at times to have her incontinence briefs changed during the night. At that time, the surveyor requested any documentation and/or assessments of the resident's skin and refusals of treatment. The RCM stated she would look for any further assessments or documentation regarding the resident's skin and refusals. On 6/16/06 at 12:00 pm, the RCM provided documentation of the same quarterly nursing assessment, dated 4/17/06, which documented, "Hx [history] recurrent yeast rash & [and] of Stg [stage] II PU [pressure ulcer] Rt [right] buttock skin on buttocks sl [slightly] discolored [no] open	F 280		

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F 280	Continued From page 56 area." No further assessments or documentation about the resident's skin or refusal of care was received. The care plan did not direct staff regarding the resident's refusals of treatments and assessments of his skin ulcers.	F 280 F281	It is the policy of Lacrosse Health and Rehab to provide or arrange for services that meet professional standards of quality. To enhance currently compliant operations and under the direction of the DON, on 7/13/06 the licensed nursing staff will be in-serviced concerning the discontinuance of treatments when they are no longer necessary. The training will emphasize that physicians should be contacted to report the status of any treatment that may no longer be needed and that as changes in orders are received, the care plan should be updated to reflect any changes. Both cited residents have had their orders and care plans revised. Because all residents with treatment orders are potentially affected by the cited deficiency, during the week of 7/17/06 the DON will perform audits of all resident treatment records. The audit will focus on any treatments no longer necessary. The physician will be contacted with an update, as necessary. Effective 7/21/06, a quality-assurance program will be implemented under the supervision of the DON to monitor treatment records for necessity of continuation of treatment orders. The DON or designee will perform random audits of resident treatment records.	7/24/06
F 281 SS=D	483.20(k)(3)(i) COMPREHENSIVE CARE PLANS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation and record review, it was determined the facility failed to ensure services provided or arranged by the facility met professional standards of quality. The facility failed to ensure that physician orders were followed. This was true for 2 of 18 sampled residents (#8 and 14). The findings include: 1. Resident #8 was admitted to the facility on 2/17/06 with diagnoses which included emphysema, chronic bronchitis, cor pulmonale, coronary artery disease and Parkinsonism. The resident's record contained medication and treatment recapitulation orders dated and signed by the physician on 4/6/06. Listed on this form was an order for "knee high ted hose on in am, off at hs (hour of sleep)." Observations on 6/14/06 at 8:00 am and 10:15 am, revealed the resident not wearing the prescribed ted hose.	F 281		

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F 281	Continued From page 57 On 6/14/06 at 12:15 pm, the Resident Care Manager (RCM) was interviewed regarding resident #8's ted hose. The RCM stated the resident had a history of some edema, but would investigate further as to why the resident was observed not wearing the ted hose. On 6/14/06 at 1:45 pm, the RCM was interviewed again. The RCM stated the resident had not been wearing the ted hose for quite some time, due to the fact that he had not been experiencing any more problems with edema. She stated the order had not been discontinued, but that she would fax the physician and request an order to discontinue the ted hose. 2. Resident #14 was admitted to the facility on 6/3/02 with the diagnoses of dementia, cerebral vascular accident, chronic pain syndrome, osteoporosis and macular degeneration. The resident's record contained a "Physician's Recapitulation Order" form for June 2006. Listed on this form was an order for "knee high ted hose on in am [morning], off at hs [hour of sleep]." Observations on 6/16/06 at 6:30 am, revealed the resident not wearing the prescribed ted hose. At this time a CNA was asked about the ted hose and replied, "she has not worn those in a long time." When asked about how long, the CNA replied, "probably about four months." On 6/16/06 at 10:35 am, the DON was interviewed. He was informed the resident was not wearing ted hose and what the CNA had said. The DON indicated that lately the resident had not had the swelling in her legs that she used to and he would check on the matter. At 1:15 pm, the	F 281	Any deficiencies will be corrected on the spot, and the findings of the quality-assurance checks will be documented and submitted at the quality assurance committee meeting for further review or corrective action.	

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F 281	Continued From page 58 DON indicated the order was discontinued because it was no longer needed.	F 281 F311	It is the policy of Lacrosse Health and Rehab to give residents appropriate treatment and services to maintain or improve his or her abilities.	7/24/06
F 311 SS=D	483.25(a)(2) ACTIVITIES OF DAILY LIVING A resident is given the appropriate treatment and services to maintain or improve his or her abilities specified in paragraph (a)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on observations, resident and staff interviews, and record review, it was determined the facility failed to ensure residents received supervision, encouragement, cueing and physical assistance during meals. This was true for 1 of 18 sampled residents [#2] and 2 of 9 random residents [#31 and #32] who ate on the Special Care Unit. Findings include: 1. Resident #2 was admitted to the facility on 4/27/99 with the diagnoses of rectal prolapse, dementia and ischemic colitis. The resident's most recent quarterly MDS, dated 04/12/06, documented the resident was moderately impaired-decisions poor; cues/supervision required. This assessment also documented the resident was easily understood by others and could easily understand others. This MDS documented the resident was independent with eating but required set up help. The "Activities of Daily Living Tracking Record" dated February 2006 under "Eating", documented that resident #2 required Supervision: oversight, encouragement, or cueing needed.	F 311	Please note that none of the cited residents have weight loss or hydration issues. To enhance currently compliant operations and under the direction of the DON, on 7/11/06 the nursing assistants and on 7/13/06 the licensed staff will receive in-service training. The training will emphasize ensuring residents receive supervision, encouragement, cueing and physical assistance during meals as well as intervention when residents eat less than 50% of their meal. Because all residents that are not independent with eating are potentially affected by the cited deficiency, on 7/12, 7/13 and 7/14/06 the DON and each RCM will observe dining services to ensure that the nursing assistants and licensed staff are offering the assistance required by each resident. Any concerns will be addressed on the spot with staff education as necessary. Effective 7/17/06, a quality-assurance program was implemented under the supervision of the DON to monitor that staff are providing the required assistance during meals.	

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	135042	A. BUILDING _____ B. WING _____	06/19/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LACROSSE HEALTH & REHAB	210 W LACROSSE AVE COEUR D'ALENE, ID 83814

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 311	Continued From page 59 The "Nutrition Risk Data Collection and Assessment" dated 12/12/04 scored resident #2 at 11, with a score of 8 or higher showing that the resident was a high nutritional risk. The Nutritional progress notes dated 3/17/06 stated, "Per CNA, res [resident] cont. [continues] to need encouragement to eat." The nursing progress notes dated 6/05/06 summary stated, "Cues to eat/drink-eats 1/4 to 1/2." Throughout the survey, resident #2 was observed during multiple dining situations. These observations are as follows: *06/13/06 at 7:50 am, resident #2 was in the dining room with her meal tray in front of her. The next 20 minutes the resident ate approximately 1/4 of her meal. At no time did a staff member approach her to supervise or cue her to eat more of her meal. At approximately 8:25 am, a staff member approached the resident and asked if she was "all done?" The resident indicated she was and the staff member took her tray. The staff did not ask if she wanted anything else or offer encouragement to drink her remaining fluids. * 06/14/06 at 12:25 pm, the resident was served her lunch tray. The resident was observed for the next 30 minutes while she ate 1/4 of her meal. At no time did a staff member approach the resident to offer her supervision or cueing to eat or drink any liquids. At approximately 12:55 pm a staff member approached resident #2 to inquire if she was finished eating. Resident #2 indicated that	F 311	The DON or designee will perform random meal time audits to ensure the degree of assistance required is being offered as well as that alternatives are offered if a resident eats less than 50% of their meal. Any deficiencies will be corrected on the spot, and the findings of the quality-assurance checks will be documented and submitted at the quality-assurance committee meetings for further review or corrective action.	

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F 311	Continued From page 60 she was and the staff member removed her tray. The staff did not ask if she wanted anything else or offer encouragement to drink her remaining liquids. Resident #2's Dietary Meal Monitoring sheet was reviewed for the months of April, May and June 2006. They documented the following: *In April, there were 5 meals where the resident consumed none of the meal, 1 meal with 10% consumption, 46 meals with 25% consumption, 31 meals with 50% consumption, 7 meals with 75% and 2 meals with 100% consumption. For the meals with 50% or less eaten, there was no documentation indicating the resident was offered an alternative. *In May, there were 5 meals where the resident consumed none of the meal, 43 meals with 25% consumption, 33 meals with 50% consumption and 8 meals with 75% consumption. For the meals with 50% or less eaten, there was no documentation indicating the resident was offered an alternative. *In June, there were 5 meals where the resident consumed none of the meal, 20 meals with 25% consumption, 10 meals with 50% consumption and 6 meals with 75% consumption. For the meals with 50% or less eaten, there was no documentation indicating the resident was offered an alternative. On 6/15/06 at 3:00 pm, the Resident Care Manager (RCM) for the Special Care Unit was interviewed regarding resident #2's eating. At this time the RCM acknowledged that resident #2's care plan included interventions to encourage the resident to eat and drink. She also acknowledged the many documented incidents when the	F 311		

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F 311	Continued From page 61 resident's meal intake was 50% or less and no alternatives were documented. 2. Random Resident #32 was admitted to the facility on 03/01/05 with diagnoses of dementia. The resident's most recent quarterly MDS, dated 05/05/06, documented the resident was moderately impaired-decisions poor; cues/supervision required. This assessment also documented the resident had the ability to make herself understood and understand others. This MDS documented the resident needed supervision-oversight, encouragement or cueing with eating, in addition to set up help. The following was observed: *06/13/06 at 7:50 am, random resident #32 was in the dining room with her meal tray in front of her. The next 20 minutes the resident ate approximately 1/4 of her meal. At no time did a staff member approach her to supervise or cue her to eat more of her meal. At approximately 8:25 am, a staff member approached the resident and asked if she was "all done?" The resident indicated she was and the staff member took her tray. The staff did not ask if she wanted anything else or offer encouragement to drink her remaining fluids. * 06/14/06 at 12:25 pm, the resident was observed during lunch and was served her lunch tray. The resident was observed for the next 30 minutes while she ate 1/4 of her meal. At no time did a staff member approach the resident to offer her supervision or cueing to eat or drink any liquids. At approximately 12: 55 pm a staff member approached resident #32 to inquire if she was finished eating. Resident #32 indicated that	F 311		

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F 311	Continued From page 62 she was and the staff member removed her tray. The staff did not ask if she wanted anything else or offer encouragement to drink her remaining liquids. Resident #32's Dietary meal monitoring sheet was reviewed for the months of March, April and May 2006. They documented the following: *In March, there were 3 meals where the resident consumed none of the meal, 18 meals with 25% consumption, 62 meals with 50% consumption and 8 meals with 75% consumption. For the meals with 50% or less eaten, there was no documentation indicating the resident was offered an alternative. *In April, there were 5 meals where the resident consumed none of the meal, 14 meals with 25% consumption, 56 meals with 50% consumption, 10 meals with 75% consumption and one meal with 100% consumption. For the meals with 50% or less eaten, there was no documentation indicating the resident was offered an alternative. *In May, there were 7 meals where the resident consumed none of the meal, 21 meals with 25% consumption, 49 meals with 50% consumption, 13 meals with 75% consumption and 2 meals with 100% consumption. For the meals with 50% or less eaten, there was no documentation indicating the resident was offered an alternative. On 6/15/06 at 3:00 pm, the RCM for the Special Care Unit was interviewed regarding resident #32's eating. At this time the resident care manager acknowledged that resident #32's care plan included interventions to encourage the resident to eat and drink. She also acknowledged the many documented incidents when the resident's meal intake was 50% or less and no	F 311		

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F 311	Continued From page 63 alternatives were documented. 3. Random Resident #31 was admitted to the facility on 12/22/05 with a diagnosis of dementia. The resident's most recent quarterly MDS, dated 05/05/06, documented the resident was moderately impaired-decisions poor; cues/supervision required. This assessment also documented the resident had the ability to make herself understood and understand others. This MDS documented the resident needed supervision-oversight, encouragement or cueing with eating in addition to set up help. The following was observed: *06/13/06 at 7:50 am, random resident #31 was in the dining room with her meal tray in front of her. The next 20 minutes the resident ate approximately 1/4 of her meal. At no time did a staff member approach her to supervise or cue her to eat more of her meal. At approximately 8:25 am a staff member approached the resident and asked if she was "all done?" The resident indicated she was and the staff member took her tray. The staff did not ask if she wanted anything else or offer encouragement to drink her remaining fluids. * 06/14/06 at 12:25 pm, the resident was observed during lunch and was served her lunch tray. The resident was observed for the next 30 minutes while she ate 1/4 of her meal. At no time did a staff member approach the resident to offer her supervision or cueing to eat or drink any liquids. At approximately 12: 55 pm a staff member approached resident #25 to inquire if she was finished eating. Resident #25 indicated that she was and the staff member removed her tray.	F 311		

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F 311	Continued From page 64 The staff did not ask if she wanted anything else or offer encouragement to drink her remaining liquids. Resident #31's Dietary meal monitoring sheet was reviewed for the months of March, April and May 2006. They documented the following: *In March, there were 7 meals where the resident consumed none of the meal, 28 meals with 25% consumption, 35 meals with 50% consumption, 19 meals with 75% consumption and 4 meals with 100% consumption. For the meals with 50% or less eaten, there was no documentation indicating the resident was offered an alternative. *In April, there were 5 meals where the resident consumed none of the meal, 38 meals with 25% consumption, 35 meals with 50% consumption, 9 meals with 75% consumption and 9 meals with 100% consumption. For the meals with 50% or less eaten, there was no documentation indicating the resident was offered an alternative. *In May, there were 9 meals where the resident consumed none of the meal, 27 meals with 25% consumption, 40 meals with 50% consumption, 10 meals with 75% consumption and 5 meals with 100% consumption. For the meals with 50% or less eaten, there was no documentation indicating the resident was offered an alternative. On 6/15/06 at 3:00 pm, the RCM for the Special Care Unit was interviewed regarding resident #31's eating. At this time the resident care manager acknowledged that resident #31's care plan included interventions to encourage the resident to eat and drink. She also acknowledged the many documented incidents when the resident's meal intake was 50% or less and no alternatives were documented.	F 311		

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F 311	Continued From page 65 The facility failed to provide to residents the necessary supervision, encouragement, cueing and physical assistance needed during meals.	F 311 F312	It is the policy of Lacrosse Health and Rehab to ensure residents unable to carry out activities of daily living receive necessary services.	7/24/06
F 312 SS=D	483.25(a)(3) ACTIVITIES OF DAILY LIVING A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation and record review, it was determined the facility failed to ensure a resident who required assistance with oral care received the necessary assistance. This was true for 1 of 18 sampled residents (#17) . The findings include: Resident #17 was admitted to the facility on 5/23/06 with diagnoses which included Alzheimer's dementia. The resident's record revealed an admission MDS, dated 6/1/06, which indicated the resident was moderately impaired with cognitive skills for daily decision making and required extensive assistance of one staff person with personal hygiene. The resident's plan of care, dated 6/1/06, documented that staff were to provide physical assistance with "oral care daily and PRN."	F 312	To enhance currently compliant operations and under the direction of the DON, on 7/11/06 the nursing assistants will receive in-service training. The training will emphasize providing for the grooming and hygiene of residents that require assistance. Because all residents requiring assistance with their activities of daily living are potentially affected by the cited deficiency, during the week of 7/10/06 the staff development coordinator observed the nursing assistants while providing resident cares. No other residents were affected. Effective 7/17/06, a quality-assurance program will be implemented under the supervision of the DON to monitor care delivery. The staff development coordinator or designee will perform random care delivery audits to ensure all aspects of resident cares are being consistently performed. Any deficiencies will be corrected on the spot, and the findings will be documented and submitted at the quality assurance committee meeting for further review or corrective action.	

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F 312	Continued From page 66 On 6/15/06 at 7:35 am, two CNAs were observed providing morning cares for resident #17. However, it was observed that no oral care was provided for the resident.	F 312 F314	It is the policy of Lacrosse Health and Rehab to ensure that a resident that enters the facility without pressure sores do not develop pressure sores unless clinically unavoidable. Please note that all residents cited in this sample were admitted to the facility with ulcers or ulcers that developed were clinically unavoidable. To enhance currently compliant operations and under the direction of the DON, on 7/13/06 the licensed nurses and on 7/20/06 the nursing assistants will receive in-service training concerning preventive measures and documentation. The training will emphasize the importance of following the care plan to ensure prevention of skin issues and ensuring ongoing documentation of skin issues and compliance with treatments. The cited residents have had care plan and / or assessment revisions. Because all residents identified at risk for skin issues are potentially affected by the cited deficiency, during the weeks of 7/10/06 and 7/17/06 residents Skin Integrity Assessment: Prevention and Treatment Plan of Care will be reviewed and revised to ensure they reflect the current level of care required. Those residents with a history of refusing care interventions will be referred to social services for appropriate assessment and care planning.	7/24/06
F 314 SS=E	483.25(c) PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, resident, family and staff interview, and record review, it was determined the facility did not ensure consistent preventive measures were implemented for residents at risk for developing pressure ulcers. The facility also failed to ensure ongoing complete and measurable documentation of current pressure ulcers. This was true for 6 of 21 sampled residents (#'s 3, 4, 12, 14, 15 and 17). The findings include: 1. Resident #3 was admitted to the facility on 11/8/01 and re-admitted on 6/20/04 with diagnoses which included diabetes mellitus with peripheral neuropathy, necrotic diabetic ulcer of the left foot, and osteomyelitis of the left foot.	F 314		

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F 314	Continued From page 67 According to the resident's annual MDS assessment, dated 12/16/05, the resident was independent with cognitive skills for daily decision making, required limited assistance of one staff person with bed mobility, extensive assistance of two staff persons with transfers, and extensive assistance of one staff person with dressing. The assessment also indicated the resident had limitations of range of motion and partial loss of voluntary movement to one side of the body which affected his leg and foot. It was also documented the resident had one Stage II stasis ulcer and a history of resolved ulcers in the last 90 days. The resident's quarterly MDS assessment, dated 5/18/06, indicated the following changes: The resident was assessed as having modified independence with cognitive skills for daily decision making; showed some behavioral symptoms of being verbally abusive, physically abusive, socially inappropriate, and resistive to cares; and was now independent with dressing. Further review of the resident's record revealed a "Skin Grid - Pressure/Venous Insufficiency Ulcer/Other" form, dated 2/21/06, documenting an initial site of a right lateral ankle skin ulcer assessed at a Stage II and a description of it as being both a diabetic and pressure ulcer. Review of the resident's plan of care, updated 5/25/06, revealed a "Skin Integrity Assessment: Prevention and Treatment Plan of Care." On the assessment side of the form it was documented, "Impaired/decreased mobility and decreased functionality...LE [lower extremity] ulcers,	F 314	Effective 7/21/06, a quality-assurance program will be implemented under the supervision of the DON to monitor care delivery. The DON or designee will perform random audits to ensure the plan of care is being followed for residents requiring preventive measures to prevent skin breakdown. Random audits to ensure assessment and care planning is complete and measurable will be conducted by the DON or designee. Any deficiencies will be corrected on the spot, and the findings of the quality-assurance checks will be documented and submitted at the quality-assurance committee meeting for further review or corrective action.	

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F 314	Continued From page 68 polyneuropathy...Co-morbid Conditions: Renal Disease, Diabetes Mellitus, anemia...Impaired/diffuse or localized blood flow, Venous Insufficiency, Diabetic Neuropathy, resident refusal: @ [at] times refuses tx's [treatments]/LN's to [check] skin/use heel floating bolster." On the interventions side of the form it was documented, "Protect/elevate heels: Encourage to float heels using bolster...Resident Refusal: Education, demonstrates understanding of noncompliance, encourage to allow tx or assessment of wounds/skin, Treatment: Monitor wound weekly and PRN..." On a separate form a problem area, dated 12/4/05, indicated a problem of "Decreased functional status r/t [related to] neuropathy, stasis ulcer [left] ft [foot] chronic, Actual/Potential areas of concern: ADL's, Urinary, Fluids, DM [diabetes mellitus]." The documented intervention included, "...Float heels in bed - foot protector when OOB [out of bed]..." Review of the resident's record revealed treatment flowsheets for the months of April and May 2006 on which it was documented, "Weekly Skin Assessment by RCM (-) No new areas (+) new areas noted." On 4/5/06, 4/12/06, 4/19/06, 4/26/06, 5/2/06, 5/9/06, 5/15/06, 5/23/06, and on 5/30/06, there was documentation of a LN's initials with a circle around them. On the back of the form it was documented that the resident "refused skin rounds." Observation of the resident on 6/13/06 at 7:00 am, revealed the resident sitting in his wheelchair. A protective boot was observed on his left foot, however, there was no protective footwear observed on his right foot. The same observations were made on 6/13/06 at 10:25 am	F 314		

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F 314	Continued From page 69 and 12:35 am, and 6/14/06 at 1:45 pm. On 6/14/06 at 11:45 am, the Resident Care Manager (RCM) was interviewed regarding the resident's refusals of treatments, skin assessments, and the lack of specific guidance in the resident's care plan regarding his refusals of treatments and assessments. The RCM was also questioned about the resident's skin ulcer on the right lateral ankle. The RCM stated the ulcer began as a diabetic ulcer on the right lateral ankle and was exacerbated due to pressure. She stated the resident refused to wear a foam boot to his right foot. The surveyor then repeated the request to the RCM for supporting documentation regarding the resident's refusals. On 6/14/06 at 1:45 pm, the RCM stated that there was no current documentation in the resident's chart regarding his refusal of the protective boots or his refusal to float his heels. On 6/15/06 at 11:00 am, the RCM acknowleged the resident was not wearing any protective footwear on his right foot. She reiterated that the resident did refuse for the LNs to assess his skin and wear the protective footwear and provided the surveyor with a "Mood and Behavioral Symptom assessment/Plan of Care" dated 1/05. However, this care plan documented that the resident was at times in a "bad mood" and was at times inappropriate with staff. The care plan did not direct staff regarding the resident's refusals of treatments and assessments of his skin ulcers. According to federal guidance for F314, "In order for a resident to exercise his or her right appropriately to make informed choices about	F 314		

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F 314	Continued From page 70	F 314		

care and treatment or to refuse treatment, the facility and the resident (or the resident's legal representative) must discuss the resident's condition, treatment options, expected outcomes, and consequences of refusing treatment. The facility is expected to address the resident's concerns and offer relevant alternatives, if the resident has refused specific treatments." Furthermore, regarding the resident's care plan, "If the resident refuses or resists staff interventions to reduce risk or treat existing pressure ulcers" the care plan must reflect the efforts of the facility to "seek alternatives to address the needs identified in the assessment."

2. Resident #4 was admitted to the facility on 8/16/05 with diagnoses which included Alzheimer's disease, coronary artery disease, history of myocardial infarction, and degenerative joint disease.

The resident's admission MDS assessment, dated 8/26/05, indicated the resident was moderately impaired with cognitive skills for daily decision making, required extensive assistance of two staff persons for bed mobility and transfers, was incontinent of both bowel and bladder, and had partial loss of voluntary movement. The assessment also indicated the resident had one Stage II pressure ulcer.

Review of the resident's record revealed a "Skin Integrity Assessment: Prevention and Treatment Plan of Care", revised 5/25/06, indicating the resident was at risk related to:
"Impaired/decreased mobility and decreased functionality: DJD [degenerative joint disease], Dementia...Co-morbid Conditions: Bowel

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F 314	Continued From page 71 Incontinence, Bladder Incontinence...History of a healed ulcer..." The documented interventions included the following: "...Turning and Repositioning Program...Protect/elevate heels: float heels...Lay down between meals...assist to reposition prn [as needed]..." Observations of resident #4 on 6/13/06 at 6:45 am, revealed the resident in his wheelchair sitting at the nursing station. It was observed that the resident was not repositioned from his wheelchair or assisted with incontinence until 10:00 am. On 6/13/06 at 10:25 am, the resident was observed in bed with his heels directly on the mattress. The resident was observed in this same position at 11:00 pm and at 11:20 pm. On 6/14/06 at 5:30 am, the resident was observed in bed with his heels directly on the mattress. The resident was observed in this same position at 6:30 am, when 2 CNAs assisted the resident with incontinence cares and positioned the resident in his wheelchair. It was observed that the resident was not repositioned from his wheelchair or assisted with incontinence until 10:15 am. At 10:45 am, that same day, the resident was observed to be in bed with his heels not floated. On 6/14/06 at 11:45 am, the RCM was interviewed regarding the observations of the resident's heels not being floated and regarding the lack of repositioning and toileting for a resident who required extensive assistance with repositioning and had a history of a pressure ulcer on his buttocks. The RCM was also questioned about the lack of clearly defined interventions on the care plan. The RCM stated the resident was to be layed down between meals and to be toileted before and after meals and at	F 314		

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F 314	Continued From page 72 bedtime, usually every 2 hours. On 6/14/06 at 2:00 pm, the resident's buttocks were observed in the presence of the RCM. The skin on both sides of the buttocks was reddened, but the areas were blanchable to touch. According to federal guidance for F314 regarding moisture and its impact on skin, "Both urine and feces contain substances that may irritate the epidermis and may make the skin more susceptible to breakdown...irritation or maceration resulting from prolonged exposure to urine and feces may hasten skin breakdown..." Regarding repositioning, federal guidance for F314 states, "Repositioning is critical for a resident who is immobile or dependent upon staff for repositioning...The care plan for a resident who is reclining and is dependent on staff for repositioning should address position changes to maintain the resident's skin integrity. This may include repositioning at least every 2 hours or more frequently depending upon the resident's condition and tolerance of the tissue load (pressure)...Many clinicians recommend a position change 'off loading' hourly for dependent residents who are sitting or who are in bed or a reclining chair with the head of the bed or back of the chair raised 30 degrees or more..." 3. Resident #15 was admitted to the facility on 11/3/05 with diagnoses which included cerebrovascular accident (CVA) with left sided weakness, hypertension, and depression. According to the resident's admission MDS assessment, dated 11/13/05, the resident was identified as having modified independence with	F 314		

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F 314	Continued From page 73	F 314		

cognitive skills for daily decision making, required extensive assistance with bed mobility, transfers, dressing, toilet use and personal hygiene. No skin ulcers or history of resolved ulcers were identified.

Review of the admission skin assessment, dated 11/3/05, revealed no skin breakdown on the resident's buttocks area.

Review of the resident's "Skin Integrity Assessment: Prevention and Treatment Plan of Care," dated 11/3/05, documented the resident was at risk related to: "Impaired/decreased mobility and decreased functionality: S/P [status post] CVA Resistive to care @ [at] x's [times]..." Under the "Skin (describe)" section of the assessment, it was documented, "Healthy skin - clean and well - hydrated Admitted c [with] bruises & (Bruises easily) ST [skin tear] on ASA [admission skin assessment] Hx [history] ST @ elbow Lt [left] arm flaccid (partially) needs molded trough position in w/c [wheelchair]." On the intervention side of the care plan, it was documented, "...turning and repositioning program q 2° [hours] at noc [night] or noc rounds." On 12/20/05, it was documented, "Res[ident] refuses @ x's..." There was no further documentation regarding the resident's refusals of treatment or what alternative measures staff should follow. The care plan also indicated the following interventions regarding "Skin Protection: ...Initiate B/B [bowel and bladder] Program as appropriate: Scheduled Toileting: 0500 [5:00 am] & 0700 [7:00 am] Plus per request; Provide incontinent Care: q [every] 2° [hours] & prn [as needed]..." Under the "Treatment" section of the skin integrity care plan, it was documented:

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F 314	Continued From page 74 "Monitor Rash weekly and PRN..." Further review of the resident's record revealed a quarterly nursing assessment (photocopied at the facility the afternoon of 6/15/06), dated 4/17/06. The nursing assessment revealed no documentation regarding a skin assessment or any breakdown in the resident's skin. On 6/15/06 at 1:15 pm, resident #15 and her family member were interviewed. The resident and the family member indicated concerns about not receiving timely assistance to the toilet from staff. The resident and the family member also stated they were concerned about the resident's skin on her buttocks area. The family member stated the resident had a sore on her bottom since October of 2005, and it had been on-going since. The family member stated the resident had not been turned and repositioned as needed during the night and was concerned that the sore was not healing. On 6/16/06 at 10:20 am, resident #15 consented to have the surveyor observe her skin on her buttocks only while she was being transferred to the toilet by the aid of a CNA. Due to the brief observation, the following was observed by the surveyor: a large reddened area encompassing both sides of the resident's buttocks measuring approximately 6 to 7 inches in diameter. Inside the reddened area along the line delineating each side of the buttocks was two dark purple areas approximately the size of an egg. On 6/16/06 at 10:45 am, the RCM was interviewed. The RCM was informed of the surveyor's observations of the resident's skin.	F 314		

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F 314	Continued From page 75 The RCM stated that the resident's skin had been discolored for a long time and stated the resident had refused at times to have her incontinence briefs changed during the night. At that time, the surveyor requested any documentation and/or assessments of the resident's skin and informed the RCM that no documentation could be located previously about the resident's skin. The RCM showed the surveyor the admission skin assessment and acknowledged that it did not indicate any skin breakdown on the resident's buttocks. She stated she would look for any further assessments or documentation regarding the resident's skin and refusals. On 6/16/06 at 12:00 pm, the RCM provided documentation of the same quarterly nursing assessment, dated 4/17/06, which documented, "Hx [history] recurrent yeast rash & [and] of Stg [stage] II PU [pressure ulcer] Rt [right] buttock skin on buttocks sl [slightly] discolored [no] open area." No further assessments or documentation about the resident's skin or refusal of care was received. 4. Resident #17 was admitted to the facility on 5/23/06, with diagnoses which included Alzheimer's dementia. According to the resident's admission MDS assessment, dated 6/1/06, the resident was moderately impaired with cognitive skills for daily decision making, required extensive assistance with bed mobility, transfers, and dressing. The assessment also indicated the resident had a Stage II pressure ulcer. According to the resident's admission skin	F 314		

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F 314	Continued From page 76 assessment, dated 5/23/06, the resident had a "Bandaged L [left] heel" and indicated to "See Skin Grid - Pressure/Stasis Ulcer/Other." Review of the "See Skin Grid - Pressure/Stasis Ulcer/Other" form, dated 5/23/06, revealed the resident was admitted with a Stage II pressure ulcer to the left heel. Review of the resident's "Skin Integrity Assessment: Prevention and Treatment Plan of Care," dated 5/23/06, documented the resident was at risk related to: "Bowel Incontinence; Bladder Incontinence..." There was no documentation on the assessment related to the resident's decreased mobility or the resident's Stage II pressure ulcer. On the intervention side of the form, it was documented, "...Turning and Reposition Program...Protect/elevate heels: 6/14/06 EZ boots bilat[really] in bed. EZ boot to L [left] when in w/c..." Observations of the resident on 6/15/06 at 4:00 pm, revealed the resident in bed on his right side. A protective boot was on his left boot but not on his right. On 6/16/06 at 7:00 am, the DON was interviewed regarding the lack of documentation in the resident skin at risk assessment regarding the resident's history of a Stage II pressure ulcer and the lack of documentation regarding the resident's impaired/decreased mobility on the resident's current care plan. He stated he would try to locate documentation regarding those areas. On 6/16/06 at approximately 9:00 am, the DON provided the surveyor a revised "Skin Integrity	F 314		

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F 314	Continued From page 77 Assessment: Prevention and Treatment Plan of Care," dated 6/15/06, on which was documented, "At risk related to: Impaired/decreased mobility and decreased functionality: (describe) r/t [related to] SDAT [senile dementia Alzheimer's type]." Under "Skin: (describe)...Open Areas: Stage II Location Left heel; abrasion right calf (6/16/06); scab left calf (6/16/06)..." 5. There were similar findings for resident #12 and 14 who were dependent for care and assessed at risk for pressure ulcer development. Both residents had care planned interventions that included methods to float their heels off the mattress while in bed. Both resident's were observed on survey to be assisted to bed and their heels not floated.	F 314 F315	It is the policy of Lacrosse Health and Rehab to ensure that a resident that enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. The cited residents will have a new voiding pattern, bladder assessment and care plan completed to ensure the facility is providing services to restore as much normal bladder function as possible.	7/24/06
F 315 SS=E	483.25(d) URINARY INCONTINENCE Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, record review, resident, family and staff interview, it was determined the facility did not ensure residents bladder function	F 315	To enhance currently compliant operations and under the direction of the DON, on 7/11/06 the nursing assistants and on 7/13/06 the licensed staff will receive in-service training. The training will emphasize utilizing indwelling catheters only as appropriate, providing toileting cares as outlined in the care plan and ensuring assessments are completed with subsequent care planning. Because all residents that are incontinent or are admitted with an indwelling catheter are potentially affected by the cited deficiency, during	

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F 315	Continued From page 78 and continent status was maintained at the highest practical level of function. This was true for 6 of 21 sampled residents (#'s 3, 4, 10, 12, 14 and 17) and 1 random resident (#28) who were not offered to toilet or were not provided incontinence care in a timely manner. This was also true for 1 of 21 sampled residents (#21) who the facility allowed a Foley catheter to remain in without an appropriate medical indication for its continued use. Findings include: 1. Resident #21 was admitted to the facility on 1/26/06 with the diagnoses of cerebral vascular accident, chronic aspiration pneumonia, hypertension, hypothyroidism and a history of compression fractures. The resident's admission MDS, dated 2/8/06, documented the resident required extensive to total assistance of one to two staff for bed mobility, transfers, toileting, dressing, and personal hygiene. The resident's Urinary Incontinence Indwelling Catheter RAP, dated 2/6/06, documented "Res[ident] has had a major cva [cerebral vascular accident] with right sided deficit. She is unable to use a commode. Res currently has a {sic} indwelling cath[eter] and uses pads and briefs for occasional bowel incontinence..." A "Patient Referral" form from the transferring hospital, dated 1/26/06, documented the resident was admitted to the facility with a catheter. An undated nursing assessment form documented under the "Genitourinary" section, "Catheter: yes, Foley." The area provided to document the type of catheter and the medical justification for the catheter was blank. Resident #21's "Indwelling Urinary Catheter Data	F 315	the weeks of 7/10/06 and 7/17/06 all incontinent residents will have new voiding patterns, assessments and care plans completed. The new assessments will be compared to the MDS for accuracy. The MDS will be revised to reflect each residents current level of function. Residents with indwelling catheters in place will be reassessed for the appropriateness of their continued use. Effective 7/21/06, a quality-assurance program will be implemented under the direction of the DON to monitor the facilities incontinence program. The DON or designee will perform random audits of bladder assessments, the MDS, the plan of care to ensure all areas correlate with one another. Audits will be performed of residents with indwelling catheters to ensure they are clinically indicated. Audits will be performed to ensure that the care residents are receiving follows the plan of care as written. Any deficiencies will be corrected on the spot, and the findings of the quality-assurance checks will be documented and submitted at the quality-assurance committee meeting for further review or corrective action.	

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F 315	Continued From page 79 Collection And Assessment" form, dated 1/30/06, documented the following for catheter use justification: *Skin Wounds, pressure sores or skin irritations contaminated by urine: "skin very sensitive - stage I's form easily." *Terminal illness or severe impairment which makes bed/clothing changes uncomfortable or disruptive: "S/P [status post] CVA [with] R [right] side neglect." *Describe medical factors present: "acute CVA, hx [history] of osteoporosis [with] compression fx's [fractures]." *Describe interventions to control incontinence utilized prior to catheter placement: "placed at [hospital name] D/T [due to] inability to recognize need to use toilet and extremely fragile skin." *Physician's order for use of an indwelling catheter obtained on: was left blank. *Physician's indication for catheter use is: "S/P CVA." Resident #21's "Bladder Data Collection and Assessment" dated 1/30/06, documented the resident had functional incontinence related to "mobility/manual dexterity impairments." This assessment also documented, "has foley cath - no sensation of need to use toilet." There was no additional documentation found on this assessment related to the medical need for the catheter or any indication the facility planned to discontinue the catheter at a later date. Resident' #21's "Problem Oriented - Progress Notes" documented the following: *2/23/06 at 2:00 pm, "...U [urine] dip obtained and	F 315		

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F 315	Continued From page 80 results faxed to M.D. Urine is dark and foul smelling. *2/25/06 at 2:00 pm, "...urine cont[inues] to have foul odor [and] dark in color..." Another entry at 6:30 pm documented, "...Called [physicians's name] about CXR [chest x-ray] report. He ordered Augmentin XR per peg tube [two] gms [grams] BID [twice a day] x 10 days...Foley patent [with] dark, cloudy amber urine. Daughter states this is an improvement from yesterday. [no] [changes] to poc [plan of care]." *3/4/06 at 10:25 am, "...has foley to down drain. Yellow clear urine. Res[ident] working [with] therapies..." *3/30/06 at 5:00 am, "CNA reported res removed cath, foley intact [with] inflated balloon. Foley replaced [with] 18 Fr [french], urine present." Another entry at 10:50 am documented, "...foley draining dark urine." *4/1/06 at 10:30 am, "...Working [with] therapies [no] signs of pain or discomfort." Another entry at 8:30 pm documented, "...urine in foley cloudy. Sample taken [and] dipped +++ for leukocytes. Also mod[erate] occult blood. Called [physician's name] order for Macrobid 1st dose given..." 4/2/06 at 10:00 am, ..."F/C [foley catheter] drg [draining] clear dark yellow urine BOD [?] bag. Macrobid [illegible word] for UTI [urinary tract infection]..." 4/3/06 at 10:30 am, "...F/C intact [with] dark yellow urine draining to BOD..." 4/4/06 at 6:15 am, "...F/C dc [discontinued] [at] 2:00 pm..." 4/5/06 at 5:35 pm, "...Incont [incontinent] of B&B [bowel and bladder]. Wears briefs. AB TX [antibiotic treatment] for UTI..." A "Physician's Telephone Order" dated 4/3/06,	F 315		

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F 315	Continued From page 81 documented "D/C Foley Cath if ok [with] nursing staff..." The resident's record was reviewed and a positive urinalysis or culture and sensitivity test was not found until 4/12/06, which revealed a urinary tract infection with "Abundant Gram Positive Cocci...Enterococcus [greater than] 100,000 organisms/mL [milliliter]." On 6/16/06 at 10:40 am, the DON was interviewed and asked to provide justification of the prolonged use of a Foley catheter for this resident. The DON indicated that the Foley was used because the resident was terminal and had orders for palliative care. He provided a physician's visit note, "Palliative Care Note" dated 2/15/06, that documented, "continue supportive care per Hospice." There was no documentation in this note that indicated the resident was in pain that would make changing clothes painful or uncomfortable as outlined on the "Indwelling Urinary Catheter Data Collection And Assessment" form. Nurse's notes were reviewed from admission to discharge and no entries were found that documented the resident was ever in any pain or discomfort with repositioning when she had the Foley, or brief changes after the Foley catheter was discontinued. In fact, there were multiple entries that indicated the resident was working with therapies. Resident #21 was admitted to the facility with a Foley catheter. The facility did not adequately assess the catheter to determine the medical need for its prolonged use. The facility's	F 315		

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F 315	Continued From page 82 documentation did not support that the resident was in pain with position and/or brief changes or dressing and indicated she was participating in therapy. The resident developed symptoms of a urinary tract infection twice while the catheter was placed. The resident pulled out the cathter at one point and it was reinserted. The facility failed to ensure resident #21 had an appropriate diagnosis or medical indication for the prolonged use of a catheter. 2. Resident #12 was admitted to the facility on 1/22/04 with the diagnoses of dementia, schizophrenia, depression, hypothyroidism, and thrombocytosis. The resident's most recent quarterly MDS, dated 4/13/06, documented the resident required extensive to total assistance of one staff or two staff for transfers, ambulation, toileting, dressing and personal hygiene. This assessment indicated the resident was frequently incontinent of bowel and bladder. The resident's quarterly MDS, dated 2/9/06, indicated the resident required the same amount of assistance, but documented the resident was usually continent of bladder (one episode or less a week) and totally continent of bowel. Resident #12's "Bladder Data Collection and Assessment" dated 2/3/06, documented the resident was incontinent related to "mobility/manual dexterity impairments, dementia." The type of incontinence was determined to be "functional," and the resident was placed on a "scheduled check and change program." The form indicated residents, "who cannot sit on toilet/commode may be a candidate" for use of this program. This assessment concluded the resident was not a candidate for	F 315		

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	135042	A. BUILDING _____ B. WING _____	06/19/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 315	Continued From page 83 bladder retraining, prompted voiding or scheduled toileting. There was no documentation on this assessment that indicated a voiding pattern was determined. This bladder assessment information did not correlate to the MDS data on continence status completed in the same week. The resident's "Skin Integrity Assessment" dated 11/11/05 and updated on 4/13/06, documented a risk factor of "moisture." Under this by "Incontinence: Urine," the hand written word, "Rarely" was documented. The assessment of resident #12's continent status was conflicting between the bladder assessments, the resident's MDS data, and the skin integrity assessment. No documentation was found that a voiding schedule/pattern was done to determine the most appropriate toileting program for this resident. Resident #12's "Care Delivery Guide" dated 4/13/06, indicated the resident was incontinent and to provide, "brief [changes] routinely." The resident's hand written "Plan of Care" dated 11/11/06, documented "toilet q [every] 2 hrs [hours] and PRN [as needed]. Res[ident] uses brief R/T non recognition of toileting needs." Under the resident's "Skin Integrity Assessment: Prevention and Treatment Plan of Care" dated 11/11/06 and updated on 4/13/06, documented "Brief 2 [hours] no longer recognizes need. Scheduled Toileting q [every] 2 [hours]." The following observations of resident #12 were made during the survey: *On 6/13/06 at 12:30 pm, the resident was	F 315		

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F 315	Continued From page 84 observed sitting in her wheelchair in the dining room waiting for lunch. The resident remained in the dining room until 1:32 pm. The resident was then taken to her room and assisted to bed by one CNA via a gait belt and a pivot transfer by the resident. The resident was able to stand after instruction from the CNA and transfer to the bed. The CNA assisted the resident into bed, adjusted the bed to a low position and placed a mat by the bedside. The resident was not offered to use the toilet. The CNA did not check the resident to determine if the resident was in need of incontinent care. *On 6/14/06 at 6:45 am, resident #12 was observed sitting up in her wheelchair. She was dressed and a bag of incontinent products was on the floor. There was a very strong odor of urine in the room. The CNA in the room was asked if she had just provided incontinent care to the resident and she indicated she had. The resident's unmade bed was observed and a large 1 foot by 6 inch wet mark was on the resident's bedding where the incontinent pad had been. The resident was provided with oral care and grooming and then taken out to the hall. At 7:49 am the resident was observed in the hallway by the nurse's medication cart with her eyes closed and sleeping. She remained in the hallway until 8:00 am when she was taken to the dining room for breakfast. At 8:30 am, the resident was given her breakfast and assisted to eat. At 9:00 am, the resident remained in the dining room being assisted to eat. At 10:10 am, resident #12 was observed in the dining room for a musical activity. At 11:20 am, resident #12 was observed sitting in her wheelchair in her room. At 12:10 pm, the resident still remained in her wheelchair in her	F 315		

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F 315	Continued From page 85 room. The resident was not observed again until 12:45 pm when she was observed in the dining room awaiting the lunch meal. Resident #12 was then involved in lunch and activities until 3:00 pm, when 2 staff assisted the resident to bed. The resident again did a stand and pivot transfer without difficulty. The staff did not offer to toilet the resident, but did provide incontinent care. The resident's brief was soiled with urine. There was a date and time of the last brief change and it documented, 6/14/06 at 12:00 pm. Resident #12 was not provided incontinent care or offered to toilet every two hours as care planned. On 6/15/06 at 8:45 am, the DON was interviewed. At this time he was informed of the discrepancy in the resident's bladder assessments. The DON was informed of the surveyor's observations and was asked why the resident was not toileted given the resident's ability to stand, transfer and ambulate with staff assistance. The DON indicated he would look into it. At 12:50 pm, the DON returned and indicated the facility was going to do a voiding pattern assessment and given the results complete a new bladder assessment and update the care plan to reflect the current toileting status of this resident. On 6/16/06 at 9:55 am, resident #12 was observed. Two staff members instructed the resident to stand and ambulate into the bathroom. The resident was observed to do this task without problems. The resident went into the bathroom, staff assisted her with her clothing and sat down on the toilet. Resident #12 was instructed by the staff to use the toilet. The resident was able to	F 315		

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F 315	Continued From page 86 void into the toilet. The resident's incontinent briefs were soiled with urine, but the resident did void in the toilet. The resident then stood and the staff assisted her with perineal care and dressing. The resident then ambulated with assistance back to her bed. Both staff members verified with the surveyor that the resident did use the toilet. Resident #12 was identified by the facility's MDS data as being only occasionally incontinent of bowel and bladder on 2/9/06. The facility's bladder assessment for this time period indicated the program of choice was to check and change the resident. Scheduled toileting or prompted voiding was not used. The resident's care plan for this time indicated the resident was to be checked and changed every 2 hours. At the time of survey, the most current MDS indicated the resident's incontinent status had declined to frequently incontinent and the resident remained on a check and change program. Observations during survey of the resident's functional ability, indicated the resident would be able to get to and use the toilet with staff assistance. Observations during the survey also found the resident was not checked and changed every two hours as care planned with times of changes reaching at times 3 to 4 hours. The facility failed to ensure this resident's highest level of bladder function was maintained. 3. Resident #3 was admitted to the facility on 11/8/01 and re-admitted on 6/20/04 with diagnoses which included diabetes mellitus with peripheral neuropathy, necrotic diabetic ulcer of the left foot, and osteomyelitis of the left foot.	F 315		

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F 315	Continued From page 87 The resident's annual MDS assessment, dated 12/16/05, indicated the resident was independent with cognitive skills for daily decision making, required limited assistance of one staff person with bed mobility, extensive assistance of two staff persons with transfers, extensive assistance of one staff person with dressing, extensive assistance with toilet use, was occasionally incontinent of bowel, and continent of bladder. The assessment also indicated the resident had limitations of range of motion and partial loss of voluntary movement to one side of the body which affected his leg and foot. The resident's quarterly MDS assessment, dated 5/18/06, indicated the following changes: The resident was assessed as having modified independence with cognitive skills for daily decision making; showed some behavioral symptoms of being verbally abusive, physically abusive, socially inappropriate, and resistive to cares; and was now independent with dressing. Review of the "Bladder Data Collection and Assessment" dated 12/12/05, revealed the following documentation: Under the "Assessment" section of the form, "1. Based on above data collection, determine types(s) of urinary incontinence...Functional unable to determine need to use toilet. 2. Based on data collection and type of incontinence, determine appropriate program:" This section was left blank. Furthermore, there was no documentation that a voiding pattern had been completed for the resident. Review of the "Care Delivery Guide," dated	F 315		

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F 315	Continued From page 88 12/14/05, documented, "Bladder Incontinent disp [disposable] briefs Timed scheduled per res[ident] req[uest] Urinal; Bowel Incontinent disp briefs Bathroom..." The care plan also revealed a problem, dated 12/4/05, which documented, "Decreased functional status r/t [related to] neuropathy - Stasis ulcer L [left] ft [foot] (chronic) Actual/Potential areas of concern: ADL's, Urinary, Fluids, DM [diabetes mellitus]." The listed interventions included: "...Assist as requested for BSC [bedside commode]. Uses disposable briefs...Offer urinal and encourage use of BSC..." On 6/14/06 at 11:45 am, the Resident Care Manager (RCM) was interviewed. The RCM was questioned about the blank areas on the bladder assessment and no individualized care plan regarding the resident's incontinence status. When asked if a voiding pattern was completed for the resident on admission and subsequently thereafter, the RCM acknowledged that no voiding pattern documentation was located in the resident record. 4. Resident #4 was admitted to the facility on 8/16/05 with diagnoses which included Alzheimer's disease, coronary artery disease, history of myocardial infarction, and degenerative joint disease. The resident's admission MDS assessment, dated 8/26/05, indicated the resident was moderately impaired with cognitive skills for daily decision making, required extensive assistance for bed mobility, transfers and toilet use, was incontinent of both bowel and bladder, and had partial loss of voluntary movement. The assessment also indicated the resident had one	F 315		

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F 315	Continued From page 89 Stage II pressure ulcer. A "Bladder Data Collection and Assessment" dated 6/5/06, indicated the resident had functional incontinence and was on a "Scheduled check and change program." It was further documented the resident, "does not sit on toilet, requires special w/c [wheelchair] c [with] supports combative @ [at] x's [times]." No other bladder assessments or voiding patterns could be located in the resident's record. The resident's "Care Delivery Guide," dated 5/25/06, documented, "Bladder Incontinent briefs; Bowel Incontinent [check] routinely..." The care plan also revealed a problem, dated 5/25/06, which documented, "Bladder Incontinence (frequency): Incontinent." The listed interventions included: "...Provide adult: briefs; Change incontinent product PRN [as needed]: routinely..." The section regarding specific intervals during the day to provide assistance "based upon voiding pattern/incontinence" was left blank. Observations of resident #4 on 6/13/06 at 6:45 am, revealed the resident in his wheelchair sitting at the nursing station. It was observed the resident was not repositioned assisted with incontinence until 10:00 am. On 6/13/06 at 10:25 am, the resident was observed in bed. The resident was observed in this same position at 11:00 pm and at 11:20 pm. On 6/14/06 at 5:30 am, the resident was observed in bed. The resident was observed in this same position at 6:30 am, when 2 CNAs assisted the resident with incontinence cares and positioned the resident in his wheelchair. It was observed that the resident was not assisted with incontinence again until	F 315		